Referral Form for Medically-Recommended Massage Therapy Services: Patient Name - _____ DOB: _____

Date:_____ Diagnosis/es:_____

Treatment Plan: Frequency: _____ Duration: _____

Areas of concern:

__ Cervical ___Thoracic ___ Scapular ___Suboccipital ___Shoulder ___ Lumbar/lumbosacral ___

___ Other (specify) _____

Goals for integrating Massage Therapy into current Medical Treatment Plan:

__ Decrease pain/edema ___ Increase ROM

___Decrease muscle hypertonicity ___ Restore prior level of function

___ Increase mobility ___ Provide pt education ___

___ Integrate Massage Therapy for support of current medical treatment plan

___ Treatment of physiological responses to emotional stress, overuse, etc.

___ Provide training and recommendations for pt self-care

___ Other (specify)

_____

_____

_____ NPI: _____

Medical Provider Signature

Thank you for faxing this referral page back to River Massage, using the fax cover sheet on page 2 of this document.

Fax Cover Sheet for Medical Authorization of Therapeutic Massage

Date: _____

To: Kathy Love, MA/CCC-SLP and LMT
River Massage – 1931 S. 3rd St. Missoula, MT
Phone: 406-370-7861
Fax: 406-493-6604

From:

Phone:
Fax:

My signature below indicates my authorization for _____ to receive therapy services as detailed on the referral form following this cover.

_____ NPI: _____
Medical Provider Signature

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