Massage Therapy Prescription / Referral Form

To: Mary E LMT LLC Address: 9204 SE Mitchell St. Portland OR 97266 Phone: (503 924 9667) Email: meverittlmt@gmail.com	From (provider name): _____ Clinic Name: _____ Address:_____ _____ Phone:_____ Fax: _____ Email:_____

Regarding Patient (name): _____

DOB: _____

Treatment Is Medically Necessary:
Please treat the patient for diagnosis listed below, using modalities/procedures below that are within your scope of practice.

Diagnosis Codes: _____

Modalities/Procedures:

☐ Therapeutic Massage ☐ Manual Therapy ☐ Myofascial Release

Duration and Frequency of Treatment:

60 minute visits (4 units) # ___visits per ☐ week ☐ month

For (duration) # _____ ☐ weeks ☐ months

Treatment Goals:

☐ Decrease Pain ☐ Decrease Inflammation ☐ Decrease Muscle Spasms/Tension

☐ Increase Mobility/Range of Motion

☐ Other: _____

Additional Instructions or Comments:

_____

Physician/Provider Signature: _____

Date:_____ NPI#:_____