200 East 25TH ST Vancouver, WA 98663 * Phone: 360-5249343 * Fax: 360-992-9242

Detailed Physician's/Doctor's Referral Massage Therapy

Completion by your Doctor REQUIRED to Bill Insurance for Massage Therapy

Patient Name: __________________________ Date of Birth: ______________________
Address: ____
Billing Address: ____
SS#______________ Insurance: ________________________ Policy #:____________

Injury Date: ___________ Claim #:_______________ Condition is related to: ___MVA
___Work injury / ___Stress / ____Other injury / ___ Other medical condition

Diagnosis/ICD-10 code(s): (please SPECIFY **ALL** that apply)

Head/Jaw: ____

Neck: ____

Back/Ribs/Chest: ____

Shoulder/Arms/Legs: ____

Hips/Pelvis/Sacrum/Core: ____

ANS/PNS/Emotional/Mental/Other:______:_____________________________________

Mark:

Session Length: ___ 60 Min / ___90 Min / ___120 Min

Session Duration: __2-3x per week / __Weekly / __ Bi / __Tri Weekly / __ Monthly

Treatment Length: ___ 1-3 Months / ___3-6 Months /
___6-9 Months / ___ 9-12 Months
Patient Follow up: ___ Patient discretion / End of TX / Specific Date:_____________

Physicians Name printed_________________________________ Date: _________________

Physicians Signature:__ ____

Address____

Phone______________________________ Fax:_________________________________