Massage Therapy Prescription/Referral

Patient's Name _____ Patient's DOB _____

Diagnosis with ICD Codes:

1 _____

2 _____

3 _____

Precautions: _____

Frequency:

☐ Daily ☐ 1xW ☐ 2x W ☐ Monthly ☐ As Needed

Number of Visits: _____

Start Date: _____ End Date: _____

Physician Name (please print) _____ Physician NPI _____

Physician Address (Street, City, State, Zip) _____

Physician Phone _____ Physician Fax _____

Physician Signature _____ Date _____

WELLBEING
Center FOR Health

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