Physician's Referral

Physician's Name: _____

Physician's Address: _____

Physician's Telephone: (_____) _____

I have been treating this patient since_____for the following condition(s):_____
date

_____

_____

_____

_____

_____

_____

I have prescribed (specific massage therapy or bodywork treatment) for this patient's condition as follows:

_____

_____

_____

Rx:_____times per week for a period of_____weeks.

Please note that the following considerations/medications warrant special concern:

_____

_____

_____

Should you notice anything unusual or suspicious in the treatment or progress of this patient, please notify my office immediately.

Physician's Signature_____Date_____