1918 S. Lemay Ave.
Suite A
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underpressuretherapeutics.com

Therapeutic Massage Referral

Patient: _____ Birthdate: _____

Insurance Company / Contact: _____

Diagnosis / Codes: _____

Referring Doctor: _____ Profession: _____

Precautions:

__ Metal Implants
__ Osteoporosis
__ Spinal Fusion
__ Diabetes
__ Pacemaker
__ Heart Disease
__ Cancer
__ Pregnancy
__ Other: _____
_____

Dr. Specific Orders:

__ Massage Therapy
__ Manual Therapy Techniques
__ Acupressure / Shiatsu
__ Neuromuscular Reeducation
__ Heat Therapy
__ Cold Therapy
__ Contrast Therapy
__ Other:
_____
_____

Comments:
_____

_____

Frequency and Duration: _____ sessions every _____ for _____ weeks.

Date of next Dr. visit: _____

Date: _____ Dr. Signature: _____