Massage Referral Form

Fax to: 360-491-6809

Date:_____

Patient Name:_____

Number of Massages: 12___ or 24___

Duration: 60 min___ or 90min___

Diagnosis codes (ICD-10):

_____

Start Date of Referral:_____

Referring Provider: _____

Referring Providers NPI#:_____

Provider Signature:_____