Physician Referral

Patient Name: _____

Referral Date: _____

Diagnosis: _____

Recommended Therapy:

[ ] Manual Therapy

[ ] Deep Tissue Massage

[ ] Trigger Point Therapy

[ ] Neuromuscular Re-education

[ ] Myofascial Release

[ ] Lymphatic Drainage

[ ] Orthopedic/Sports Injury

[ ] Deep Cross Friction/Adhesions

[ ] Pre-natal Massage

[ ] Other:

Frequency & Duration:

[ ] 3x/week [ ] 2x/week [ ] 1x/week

____ weeks or ____ months

Physician Name: _____

Physician Signature: _____ Date: _____