

Self Endearment Therapeutic Massage  
Physicians Referral/Prescription for Massage Therapy Services

Prescribing Physician: \_\_\_\_\_

Prescribing Physician's NPI: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Diagnosis/ICD-10 code(s) \_\_\_\_\_

Condition is related to: \_\_\_\_ MVA \_\_\_\_ Work Injury \_\_\_\_ Other Injury \_\_\_\_ Other Medical

Number of Sessions to be performed (frequency and duration) \_\_\_\_\_

Send progress report: \_\_\_\_ every week \_\_\_\_ every two weeks \_\_\_\_ at completion \_\_\_\_ other

Special directions/comments: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physicians Name printed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_