Bodyworks
THERAPY

Physician Referral for Medical Massage

Doctor's Name: _____ License #: _____

Practice Name: _____ Date of Prescription: _____

Phone: _____ Fax: _____ Email: _____

Patient: _____ Phone: _____ D/O/B: _____

Area of focus: _____

Diagnoses: _____

Concerns/ Precautions: _____

(Please circle)

Amount: 1 2 3 4 **Frequency**: Week Month Year

Time: 30 min 60 min **Length of treatment**: 3weeks 6 weeks 12 weeks

Goals: Improve joint mobility * Decrease pain * Balance Anatomic system * Reduce mood swings

Follow up Date: _____

Doctor signature _____ Date: _____

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