



Referral for Medical Massage Therapy

Patient name: _____

Patient phone: _____

Patient DOB: _____

Referring doctor: _____

I am referring the following patient (as listed above) to Source Myo Therapy for evaluation and treatment with Carly Williamson, Licensed Massage Therapist, Ohio #33.026932

- ☐ Prevention/Health Maintenance
- ☐ Craniosacral/Craniosacral Fascial Therapy
- ☐ TMJ Disorder/Dysfunction
- ☐ Stress Reduction
- ☐ Chronic pain
- ☐ Electrical Neuromuscular Stimulation/Scar release therapy with Dolphin Neurostim OTC device (please check this box unless medically contraindicated-pacemaker, pregnancy, epilepsy/seizures, cancer)
- ☐ Other/Notes: _____

Diagnosis codes: _____

Signature of referring doctor: _____

Date: _____