

Body By Barb

Physician Referral for Massage Therapy

This form is intended to document a physician's recommendation for therapeutic massage, which may be used to support insurance reimbursement or guide treatment planning.

Client Name: _____

Date of Birth: _____

Massage Therapist Information:

Therapist Name: _____

Practice Name: _____

Phone: (____) _____

Email: _____

Fax: (____) _____

To Be Completed by Physician or Referring Provider

I am the treating provider for the client above and recommend massage therapy as part of their care plan.

Massage therapy is medically appropriate and recommended.

Massage therapy is recommended with the following limitations or precautions: _____

Relevant Diagnosis or Condition (if applicable) _____

Recommended Frequency & Duration

_____ session(s) per week for _____ weeks

Specific Treatment Goals (optional)

Pain relief

Post-injury recovery

Muscle tension reduction

Improved range of motion

Stress relief

Other: _____

Provider Information & Signature

Provider Name (Print): _____

Clinic Name: _____

Phone: (____) _____ Fax: (____) _____

Signature: _____

Date: _____

Please return this completed form to the therapist listed above.

BODY BY BARB LLC

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