# Meridian Medical Massage LLC

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## Massage Therapy Referral

Patient Name_____DOB_____
Phone Number _____
ICD-10 Diagnosis Codes_____
X-Ray, MRI/CT Scan etc. Results_____
Precautions/Special Orders_____

| **Duration** | **Frequency** | **Length** |
|---|---|---|
| ☐ 2 Weeks | ☐ 1 X Week | _____ Units |
| ☐ 4 Weeks | ☐ 2 X Week | |
| ☐ 6 Weeks | ☐ 3 X Week | |
| ☐ 8 Weeks | ☐ Other_____ | |
| ☐ Other | | |

**I certify that this patient is under my care and requires the listed care above**

Clinic Name_____
Clinic Phone _____Clinic Fax #_____
Referring Dr. Name_____
Referring Dr. Signature_____