ALASKA MASSAGE COMPANY

PHYSICIAN REFERRAL AND/OR PRESCRIPTION FOR THERAPEUTIC MASSAGE

Prescribing Physician: _____ NPI#: _____

Practice Name: _____ Rx Date: _____

Phone: _____ Fax: _____ Email:_____

Patient Name: _____Date of Birth: _____

Diagnosis / ICD10 Code(s): _____

Condition is related to:
___ MVA ___ Work Injury ___ Other Injury ___ Stress ___ Other Medical Condition

Number of sessions to be done: (list frequency & duration) _____

_____

Send progress report:

____ No progress report ___ every week ___ every two weeks

___ at the completion of prescribed treatment(s) ___ other:_____

Special Directions/Concerns/Precautions:_____

_____

_____

Physician's Signature: _____ **Date:** _____

Physician's Name Printed: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Alaska Massage Company
heather@alaskamassagecompany.com
907-917-4999 (Fax & Voice)

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Areas to be worked on: (Please check all that apply & add comments if needed)

Cranial: ___ Temporalis	___ Masseter	___ Frontalis	Other- please list ___ _____
Cervical: ___ Levator	___ Scalenes	___ SCM	__ Splenius Cervicis __ Splenius Capitis
___ Trapezius	___ Suboccipitals	Other - please list ___ _____	Other - please list ___ _____
Thoracic: ___ Rhomboid	___ Serratus Anterior	___ Trapezius	___ Serratus Posterior Superior
Shoulder: ___ Infraspinatus	___ Supraspinatus	___ Subscapularis	__ Teres Major __ Teres Minor
___ Deltoid	___ Pectoralis Major	___ Pectoralis Minor	Other - please list ___ _____
Lumbar: ___ Quadratus	___ Iliacus	___ Psoas	Other - please list ___ _____
Sacral: ___ Gluteus Maximus	___ Gluteus Minimus	___ Gluteus Medius	___ IT Band
___ Quads	___ Hamstrings	___ TFL	Other - please list ___ _____

Other: _____

Heat Therapy: NO or YES Location: _____

Cold Therapy: NO or YES Location: _____

Physician's Signature: _____ **Date:** _____

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