



# Physician's Referral

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Physician's Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

I have been treating this patient since \_\_\_\_\_ for the following condition(s):  
*date*

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I have prescribed (specific massage therapy or bodywork treatment) for this patient's condition as follows:

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Rx: \_\_\_\_\_ times per week for a period of \_\_\_\_\_ weeks.

Please note that the following considerations/medications warrant special concern:

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Should you notice anything unusual or suspicious in the treatment or progress of this patient, please notify my office immediately.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

**Please return completed form to:**

