Practitioner/Clinic Name: ____________________

Contact Information: ________________________

Physician/Health-Care Provider's Referral

Patient Information

Patient Name: ___________________________ Date of Birth: ___________

Insurance ID#: ___________________________ Date of Injury/Illness: ____________

Referred to

Provider Name: _________________________ Specialty/Type of Treatment: ___________________

Reason for Referral

Diagnosis codes—ICD-9/10: ____

Number of visits (frequency/duration): ____

Is the referral for medically necessary treatment? Yes ☐ No ☐

Description of condition:

____

____

____

Possible precautions due to condition:

____

____

____

Possible interactions with medications:

____

____

____

Referred by

Physician/Health-Care Provider Name: ____

Phone: ___________________ Fax: ___________________ Email: _____________________

Signature: ____________________________ Date: ______________

Please note: Should you notice anything unusual or significant during treatment, please notify this office immediately. Otherwise, a summary report at the end of treatment is appreciated.

MEMBER

Associated Bodywork & Massage Professionals