Arctic
CHIROPRACTIC

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Massage Therapy Referral

Patient Name: ____

Patient DOB: ______________________ **Patient Phone #:** ______________________________

Diagnosis Codes: ____________ **Description:** __________________________________

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Treatment Modality:

Massage: ☐ Gentle, ☐ Systemic, ☐ Regional, ☐ Deep, ☐ Myofascial Release, ☐ Trigger Points,
☐ Transverse Friction Massage, ☐ Manual Therapy, ☐ Other: ______________________________

Frequency and Duration:

Start Date: ______________ End Date: ______________
______________ times a week for ______________ weeks

Instructions to Work on Specific Muscles:

☐ Paraspinal, ☐ Scalenes, ☐ Sternocleidomastoids, ☐ Levator Scapulae, ☐ Trapezius, ☐ Rotator Cuff,
☐ Rhomboids, ☐ Intercostal, ☐ Latissimus Dorsi, ☐ Psoas, ☐ Glutes, ☐ Hamstring Group, ☐ Quad Group, ☐
Gastroc / Soleus, ☐ Quadratus Lumborum, ☐ Multifidi, ☐ Other: ____________________

Short and Long Term Goals:

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Other Instructions:

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TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for the diagnosis indicated above, using the procedures that are within your scope of practice.

____
Referring Provider Name

Date: ____________

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Signature of Referring Provider

Providers NPI#:______________