Massage Therapy Prescription / Referral Form

To:
RituaLuna Wellness LLC

1611 SE Bybee Blvd
Portland OR 97045

P- (971) 279-5638

F- (866) 473 0398

office@ritualunawellness.com

From:
Provider's Name:_____

Office: _____

Address:_____

Phone Number:_____

Fax Number:_____

Email address:_____

Regarding Patient (name): _____

DOB: _____

Treatment Is Medically Necessary. Please treat the patient for diagnoses listed below, using modalities/ procedures marked below that are within your scope of practice.

Diagnosis Codes (CPT): *

_____

_____

Modalities/Procedures:

☐ Therapeutic Massage ☐ Manual Therapies ☐ Myofascial Release

Duration and Frequency of Treatment:

*90 minute visits (6 units) ☐

*60 minute visits (4 units) ☐

#_____ visits ☐ total ☐ per week ☐ per month

Referral is good from _____ to _____ (date) *

Physician/Provider Signature: _____

Date: _____ NPI#: _____

* required