Massage Therapy Prescription / Referral Form

To: RituaLuna Wellness LLC

Address: 1611 SE Bybee Blvd
Portland, OR 97202
Phone: (971) 279-5638
Fax: (866) 473-0398
Email: office@ritualunawellness.com

From (provider name): ______________________________
Clinic Name: ____
Address: ____
____
Phone: ____
Fax: ____
Email: ____

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:

60 minute visits (4 units) #______ visits ☐ total ☐ per week ☐ per month

Referral is good from ________________ to ________________ (date) *

Treatment Goals:
☐ Decrease Pain ☐ Decrease Muscle Spasms / Tension
☐ Decrease Inflammation ☐ Increase Mobility / Range of Motion
☐ Other:
____

Additional Instructions or Comments:

____

Physician/Provider Signature: ____

Date: ________________________________ NPI#: ______________________________

* required