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: _____

Modalities/Procedures:

☐ Therapeutic Massage ☐ Manual Therapies ☐ Myofascial Release

Duration and Frequency of Treatment:

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

for (duration) #_____ ☐ weeks ☐ months

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#: _____