Medical Massage Referral

Licensed Medical Massage Therapist: Lynda R. Thayer LMT

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Website: **www.RadiantHealingCenter.com**

Send Form to: **RHealingCenter@gmail.com**

Patient Information

Patient Name: _____Phone _____

DOB: _____ **Email:**_____

Diagnosis / Condition (check all that apply)

☐ Adhesive Capsulitis (Frozen Shoulder)
☐ Sciatica / Lumbar Radiculopathy
☐ Cervicalgia / Neck Pain
☐ Tension or Cervicogenic Migraines
☐ Shoulder Impingement / Rotator Cuff Dysfunction
☐ Low Back Pain
☐ Myofascial Pain Syndrome
☐ Post-Injury Soft Tissue Dysfunction
☐ Other: _____

ICD-10 Code(s) (if available): _____

Treatment Prescription

☐ Medical Massage Therapy
☐ Myofascial Release
☐ Neuromuscular / Trigger Point Therapy
☐ Range of Motion & Mobility Work
☐ Manual Lymphatic Techniques (if indicated)

Frequency: ☐ 1x/week ☐ 2x/week ☐ Other: _____
Duration: ☐ 30 min ☐ 60 min ☐ 90 min
Length of Care: ☐ 2 weeks ☐ 4 weeks ☐ 6 weeks ☐ Other: _____

Ideal Outcome: Pain Reduction, Reduce Swelling and/or ROM improvement, Decreased muscle guarding and hypertonicity, improved symptom stability in chronic pain conditions

Additional Notes / Precautions:_____

Referring Provider Name: _____