

## Alpine Therapeutic Massage Referral Form

Patient Name: \_\_\_\_\_  
 is referred to Phoenix Alexander for massage therapy treatments.

Diagnosis for massage therapy:

<input checked="" type="checkbox"/>	728.85 Muscle spasm	<input type="checkbox"/>	E812.0 Coll. w/mot. vhcl. driver
<input type="checkbox"/>	723.1 Cervicalgia	<input type="checkbox"/>	E812.1 Coll. w/mot. vhcl. driver
<input type="checkbox"/>	704.0 Headache	SPRAIN/STRAIN	
<input type="checkbox"/>	710.1 Cervical polymyositis	<input type="checkbox"/>	847.0 Cervical
<input type="checkbox"/>	729.1 Cervical myalgia	<input type="checkbox"/>	847.1 Thoracic
<input type="checkbox"/>	729.1 Myositis or Myofascitis	<input type="checkbox"/>	847.2 Lumbar
<input type="checkbox"/>	710.4 Thoracic polymyositis	<input type="checkbox"/>	846.0 Lumb/Sac
<input type="checkbox"/>	724.1 Pain in thoracic spine	<input type="checkbox"/>	846.1 Sacroiliac
<input type="checkbox"/>	724.2 Lumbago (low back pain)	<input type="checkbox"/>	843.0 Hip joint/Thigh

Cause of injury: \_\_\_\_\_

Date of injury: \_\_\_\_\_

Prognosis: \_\_\_\_\_

Personal Injury Claim #: \_\_\_\_\_

Referring Dr.'s NPI Provider #: \_\_\_\_\_

L&I allowed diagnosis code: \_\_\_\_\_

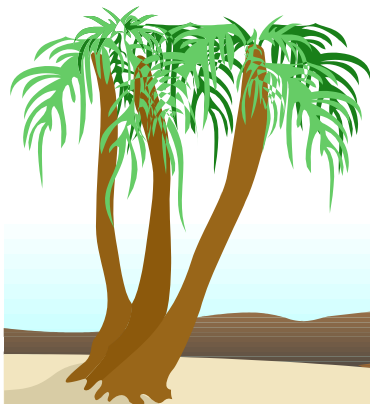
Recommended number of treatments: \_\_\_\_\_

Referring Doctor's signature: \_\_\_\_\_

Doctor's Printed Name: \_\_\_\_\_

Doctor's Office Address: \_\_\_\_\_

Doctor's Phone # \_\_\_\_\_ Fax # \_\_\_\_\_



Phoenix Alexander LMP MA#4392  
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