Self Balance Massage, INC ~ Massage Referral

8221 NE Hazel Dell Ave., Suite 103 Vancouver WA 98665 • phone (360) 977-6090 • fax (360) 836-5659

Date ____/____/____

From the Office of: _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Phone: ( ) _____ **Fax:** ( ) _____

Patient's Name: _____

Patient's Birth Date: ____/____/____ **Patient's Phone:** ( ) _____

Was patient's injury a result of an accident? **yes** **no**

If yes, was it: *job related* _____ *Auto related* _____ *Other* _____

Patient's date of Injury: ____/____/____

Claim Number: _____ **Insurance Co:** _____

_____ **Massages per week / month** **for** _____ **weeks**

please circle week or month

Diagnosis ICD 10 Code(s): _____ _____ _____ _____

Contraindications: _____

_____

Referring Physician: _____

Provider's Signature: _____