

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: _____

_____**#**____ Messages per week / month for _____**#**____ weeks
please circle week or month

Diagnosis ICD 10 Code(s): _____

Contraindications: _____

Referring Physician: _____

Provider's Signature: _____

Confidentiality Notice:

This message is intended only for the use of Self Balance Massage, INC, or the entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any copying, dissemination, or distribution of the communication is strictly prohibited. If you have relieved this communication in error, please notify the sender immediately by telephone and return the original message to us at the address printed in the "From" section of this form.