

# Medical Massage Referral to Self Balance Massage, LLC

8221 Hazel Dell Ave. Vancouver WA 98665 • (360) 977-6090 • Fax (206) 512-1085

Date \_\_\_/\_\_\_/\_\_\_

From the Office of: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (     ) \_\_\_\_\_ Fax: (     ) \_\_\_\_\_

Patient's date of Injury: \_\_\_/\_\_\_/\_\_\_

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* \_\_\_\_\_

Claim Number: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

\_\_\_\_\_ # \_\_\_\_\_ Messages per week / month      for \_\_\_\_\_ # \_\_\_\_\_ weeks  
*please circle week or month*

ICD 10 Code(s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Notes or Diagnosis: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_

## Confidentiality Notice:

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