JRTI’s Massage Therapy Program

Physician’s Referral and Release Form

Physician’s Name____ Date _______________

Physician’s Address____

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Physician’s Phone number and e-mail ____

Patient’s Name____

I have been treating this patient since________________________ for the following conditions:

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Medications that may warrant special consideration: ___________________________________

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I have prescribed specific massage for this patient’s condition as follows: __________________

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Rx:________________________ Times per week for a period of _________________ weeeks.

There is no clinical reasoning to believe that massage and bodywork would harm the patient’s progress. ____

Should you notice any unusual or suspicious progress in the treatment for this patient please contact my office immediately.

Physicians Signature____ Date _____________