FEELING GREAT
Therapeutic & Lymphatic Massage Treatment

Referral Form
For Massage Therapy Prescription

From:

Doctor:_____ Date:_____

Address:_____

Phone: (_____) _____ Email:_____

To:

Feeling Great, LLC (DBA Feeling Great Massage)
370 Maple Ave. W Ste 2
Vienna, VA 22180
Phone: 703-663-8600
email: contact@FeelingGreatMassage.com

Patient Name: _____

TREATMENT IS MEDICALLY NECESSARY

Please treat the patient for diagnoses listed below, using modalities/procedures marked below that are within your scope of practice.

Condition related to: _____

Diagnosis Codes: _____

Modalities/Procedures (CPT):

___97124 Massage Therapy
___97140 Manual Therapy- Including Lymphatic

Duration and Frequency of Treatment

_____units, _____ time(s) per week for _____ weeks. OR _____

Treatment Goals

__ Decrease Pain _____
__ Decrease Inflammation _____
__ Decrease Muscle Tension / Spasms _____
__ Decrease Swelling _____
__ Increase Mobility / Range of Motion _____
__ Other Instructions _____

Dr. Signature _____