Massage Therapy Prescription

Patient:_____

Physician: _____ **Address:** _____

Dr.'s NPI #_____

Phone: _____ **Fax**: _____

Donna Rowell
Lic. MA19512 & MM8760
Licensed Massage Therapist
615 S.W. St. Lucie Crescent # 102
Stuart, Fl 34994
(772) 781-5444 ~ Fax (772) 597-3660

PROCEDURES and MODALITIES

97140 ☐ Manual Therapy Techniques

PHYSICIAN'S DIAGNOSIS

1._____ 2._____ 3._____ 4._____

Frequency_____per week

Duration____3 months____6 months ____1 year

Special Notes:

_____
_____
_____

Dr. Signature: _____ **Date:** _____