# Massage Referral Form

**** = required field***

*Patient First & Last Name: ________________________________________

*Referral Reason *(circle one)*:

Auto Accident    Workers Comp    MN *sales tax exemption**    Other____________

*Should this patient be seen on an ASAP accommodation? *(circle one)*:

Yes    No

*Referring Physician Information

Name: ________________________________________

Professional Design: ________________________________________

NPI: ________________________________________

*Prescription Frequency & Length

Length of Visit: 60-minute massage

Total # of visits: ________________________________________

Policy Information *(if Auto Accident or Worker's Comp)*

Date of Injury: ________________________________________

Claim #: ________________________________________

Policy #: ________________________________________

DX Code: ________________________________________

**The State of MN requires a referral for massage therapy if the patient is seeking tax exemption from the service charge. Policy information not necessary for this selection.*

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