

**REFERRAL TO TOUCH MATTERS
THERAPEUTIC MASSAGE & BODYWORK**

Patient Name:

Reason for Referral

Diagnosis codes – ICD 10:

Number of visits (frequency/duration) recommended:

Description of condition:

Massage/bodywork therapy treatment goals / expectations for improvement?:

Possible massage/bodywork precautions due to condition:

Possible interactions with medications:

Approved for stretching within normal ROM? YES NO (explain)

Treatment Suggestions

(Rosalie can provide Relaxation/Wellness/Swedish; Orthopedic/Deep Tissue; NeuroMuscular Therapy; Structural Integration. If treatment is for other than Relaxation/Wellness/Swedish, please make suggestions for what myofascial areas to focus on; what areas tend to be short/tight vs. long/tight; what imbalances to focus on; etc.)

Referred by

Practitioner/Clinic Name:

Phone:

Email:

Mailing Address:

Healthcare Provider's Signature

Date

Please note: Should you notice anything unusual or significant during treatment, please notify this office immediately. Otherwise, a summary report at the end of treatment is appreciated.

TOUCH MATTERS THERAPEUTIC MASSAGE & BODYWORK
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