REFERRAL FORM

Doctor Office: ____

Address: ____

Phone : _______________________________ Fax: ______________________________

To: Yan Liao, LMT (CPT CODE 97124 MASSAGE THERAPY, 97001THERAPY EVALUATION)

Regarding Patient: ____

TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnoses indicated below.

Diagnoses: ____

TIMES PER WEEK : ___________ # OF WEEKS: ___________ # TOTAL VISITS: ____________

NUMBER OF VISITS ______ X NUMBER OF UNITS per visit _______, (One unit equals 15 minutes) = __________

Doctor's Signature:________________________________ Date:___________________

PHONE: 703-383-0338
FAX: 703-383-0322
4242 Chain Bridge Road, Suite A, Fairfax, VA 22030