Manual Therapy/Soft Tissue Mobilization Referral

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NAME ________________________________ DATE ______________

DIAGNOSIS ____________________________

- MANUAL THERAPY/SOFT TISSUE MOBILIZATION
- MYOFASCIAL RELEASE
- CROSS FIBER FRICTION DEEP ___ SUPERFICAL ___
- TRIGGER POINT THERAPY
- MASSAGE DEEP ___ SUPERFICIAL ___
- HOT PACKS

FREQUENCY ________ /WEEK _________/MONTH

PRECAUTIONS/INSTRUCTIONS _______________________________________

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REGARDING PATIENT: _____________________________, TREATMENT IS MEDICALLY NECESSARY. PLEASE TREAT PATIENT FOR THE DIAGNOSIS INDICATED ABOVE, USING THE MODALITIES THAT ARE WITHIN YOUR SCOPE OF PRACTICE.

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