PHYSICIAN/HEALTH-CARE
PROVIDER'S PRESCRIPTION/REFERRAL

REFERRED BY

Physician/Health-care Provider Name: _____

Address: _____

Phone:_____ Fax_____

Email: _____

REFERRED TO

Provider Name:

Flor Banks, Licensed Massage Therapist
3180 Peger Rd Ste 240, Fairbanks, AK 99709
(907) 460-6912
NPI: 1578096103 - Alaska LMT 101397

Specialty/type of Treatment:

PATIENT DEMOGRAPHICS

Patient Name: _____ Date of Birth:_____

Patient's address: Patient's age:_____

_____ Date of Injury/illness:_____

INFORMATION:

Number of visits (frequencyduration) _____ until (date)_____

Is the referral for medically necessary treatment? Yes☐ No☐

Diagnosis codes –ICD-9/10:
Reason for referral:
Describe the condition:
Possible precautions due to condition:
Any special instructions:
Possible interactions with medications:

Signature Date