Kneading Space
Tim Stahlke, LMT
massage wellness relaxation

TDLR License #134562
kneadingspace@gmail.com
512.970.2629

Physician/Health-Care Provider's Referral

Patient Information

Patient Name: ________________________________
Date of Birth: ________________________
Insurance ID#: ________________________________
Date of Injury/Illness: __________________________

Referred to

Provider Name: ______________________________
Specialty/Type of Treatment: ________________________

Reason for Referral

Diagnosis codes—ICD-9/10: ____
Number of visits (frequency/duration): ____
Is the referral for medically necessary treatment? Yes ☐ No ☐

Description of condition:

Possible precautions due to condition:

Possible interactions with medications:

Referred by

Physician/Health-Care Provider Name:
Phone: Fax: Email:
Date:
Signature:

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