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dba Dayton Massage Connection, LLC
208 Liberty Street
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Physician Authorization Form

Patient Name

DOB

Address

Phone

I am referring this patient to Dayton Massage Connection, LLC to receive therapeutic massage and/or wellness services for the following reason(s).

- Chronic Pain/Pain Reduction Muscle Strain/Sprain/Injury
 Stress Reduction/Fatigue Repetitive Strain Injury/Improve Flexibility
 Arthritis/Joint Pain Personal Training for Fitness or Weight Mgmt

Other:

___ Patient may utilize massage therapy PRN – Please include CPT Code

___ I would like the therapist to focus on the following areas (please list below)

| Diagnoses Code | Description/Additional Orders/Instructions |
|----------------|--|
| _____ | _____ |
| _____ | _____ |

Physician Signature

Date

Physician Name (printed)

Phone

Address

Fax