Practitioner/Clinic Name: P. Leilani Berry, LMP

Contact Information: 206-914-3885
leilani@leilanimassage.com

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: _____

Signature: _____ Date: _____

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