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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 or health and wellness services for the following reason(s).

- | | |
|--|--|
| <input type="checkbox"/> Chronic Pain/Pain Reduction | <input type="checkbox"/> Repetitive strain injury |
| <input type="checkbox"/> Stress Reduction/Fatigue | <input type="checkbox"/> Improve ROM /Muscle flexibility |
| <input type="checkbox"/> Arthritis/Joint Pain/Tendonitis | <input type="checkbox"/> Diabetes/Neuropathy |
| <input type="checkbox"/> Myalgia/Chronic Muscle Tension | <input type="checkbox"/> Headaches/Migraines/TMD |

Other:

___ Patient may utilize massage therapy PRN – Please include diagnoses 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