Office/Practice
Seneca Springs
3648 Seneca Street
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Billing/Mailing Address
14 Windcrest Drive
Cheektowaga, NY 14225-2520
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PHYSICIAN/HEALTH CARE PROVIDER REFERRAL FORM

Patient Information

Patient Name: ______________________________ Date of Birth: ______________________

Gender: ☐Male ☐Female Date of Injury/Illness: ______________________

Referred To:

Provider Name: Jennifer P. Dossett, LMT Specialty/Type of Treatment: Massage Therapy

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:

Additional comments:

Referred By

______________________ ______________________

DATE of Provider Signature Address

______________________ ______________ ______________

Provider ***SIGNATURE*** Phone Fax

______________________ ______________________

Provider ***PRINT NAME/STAMP*** Email

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