Active Peace
MATERNITY & MASSAGE

Physician/Provider Prescription/Referral Form

From Provider/Clinic Name: _____

Patient Name: (Please print below)

_____

Date of Birth: _____ Insurance ID#: _____

Claim Number: _____ Date of Injury/Illness: _____

Please treat this patient for the diagnosis listed below, using modalities and procedures within your scope of practice. This treatment is medically necessary for the health of this patient.

Referred to: ***Active Peace Maternity & Massage LLC***

Crystal Swanson, Doula, LMT CO lic# MT-116640 NPI# 1487906921

IDC 10 Diagnosis codes: _____

# of treatments: ____ # of times per week: ____ for # weeks ____

Description of condition:

Possible precautions due to condition:

Possible interactions with medications:

Referring Provider's Name: (please print below)

_____

Phone: _____ FAX: _____

Provider's NPI#: _____ Date: _____

Provider's signature: _____

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