Randall Gibson, M.Ed., LMT
3250 West Market Street, Suite 104
Fairlawn, Ohio 44333
330.701.8780
GibsonMassotherapy.com

Outpatient Referral Form

Patient's Name: _____

Date of Birth: _____

I am referring this patient for massage therapy evaluation and treatment.

Reason:

- ☐ Prevention / Health Maintenance
- ☐ Emotional Trauma
- ☐ TMJ Related Problems
- ☐ Chronic Pain
- ☐ Stress
- ☐ Fibromyalgia
- ☐ Nerve Compression Syndrome
- ☐ Strain / Sprain Injury

Other / Notes: _____

_____

_____ _____

Signature of referring physician Date

_____ _____

Print name Phone