MEMPHIS MYOFASCIAL RELEASE

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Myofascial Release Therapy Order **☐ OT Evaluate & Treat with Myofascial Release**

Patient Name: _____ Contact: _____

Insurance Provider(s): _____

Diagnosis: _____ ICD-10: _____

Tx Frequency:
- ☐ PRN
- ☐ 1x week
- ☐ 2x week
- ☐ 3x week
- ☐ at therapist's discretion
- ☐ Other: _____

Tx Duration:
- ☐ PRN
- ☐ x1 week
- ☐ x2 weeks
- ☐ x3 weeks
- ☐ at therapist's discretion

Practitioner's Signature: _____ **Date:** _____

**This prescription shall suffice as a letter of medical necessity with valid practitioner signature*

Thank you for your referral!