MASSAGE THERAPY REQUISITION FORM

Colette Slone, RMT

A8-80 Birmingham St. Etobicoke ON M8V3W6
Tel: 416-200-8591 | coletteslonermt@gmail.com

DATE: _____

PATIENT NAME: _____ D.O.B.: _____

PHYSICIAN NAME, ADDRESS, TELEPHONE:

REFERRED TO: Colette Slone, Registered Massage Therapist

**Please note that in accordance with CMTO Standards of Practise, all RMTs are required to conduct a full assessment, intake and treatment plan for each individual patient. When necessary, a referral to another HCP may be provided to the patient by the practitioner.*

FOR ASSSEMENT & TREATMENT OF (PHYSICIAN'S DIAGNOSIS):

- ☐ Migraines
- ☐ Cervicogenic Headaches
- ☐ Cervical Pain (Acute/Sub-Acute Strain, Whiplash Injury, Chronic, etc.)
- ☐ Jaw Pain (TMD)
- ☐ Rotator Cuff Strain/Sprain **R L**
- ☐ Carpal Tunnel Syndrome **R L**
- ☐ Thoracic/Dorsal Pain (Interscapular Muscle Strain, Scapular Pain, etc.) **R L**
- ☐ Non- Specific Low Back Pain (Lumbar Strain/Sprain, Acute/Sub-Acute/Chronic)
- ☐ Disc Herniation/ Sciatica (Neuralgia, Impingement) **R L**
- ☐ Hip/Thigh Pain (Non-Specified)
- ☐ Knee (Strain/Sprain, Chronic, Injury Rehab) **R L**
- ☐ Foot/Ankle (Strain/Sprain) **R L**
- ☐ Plantar Fasciitis **R L**

- ☐ Mood Disorder Musculoskeletal Symptom Management _____
- ☐ General Musculoskeletal Pain Management _____
- ☐ Spasm of Muscle _____
- ☐ Other _____

RECOMMENDED PLAN OF CARE:
____ Weeks OR ____ Times per Month for ____ Month(s) OR ____ PRN

COMMENTS: _____

PHYSICIAN SIGNATURE: _____