(place patient label here)

Patient
Name:___________________________

PROVIDER ORDERS

Order Set Directions:

- **(√)- Check orders to activate; Orders with pre-checked box ☑ will be followed unless lined out.**
- **Initial each place in the pre-printed order set where changes such as additions, deletions or line outs have been made**
- **Initial each page and Sign/Date/Time last page**

Diagnosis: ____

Allergies with reaction type:____

In-Patient Massage Therapy

Version 2 05/14/2014

Therapeutic massage per patient request PRN if not in conflict with medical treatment.

Provider Signature:____Date:__________Time:_________