ACUPUNCTURE REFERRAL FORM

jintripp@yahoo.ca
250-388-3669

Referring Physician: _____

Address: _____

Phone: _____ **Fax:** _____

E-mail: _____

For completion by Referring Physician:

I wish to refer my patient to receive acupuncture treatments.

Date of Referral: _____

Patient's Name: _____

Patient's Date of Birth: _____

Reason for Referral / Symptoms: _____

_____

_____

Diagnosis (if applicable)_____ **ICD-9 code(s)**_____

Physician's Signature: _____

Progress Report: none ____ verbally by patient ____ end of treatment ____

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