Physician's Referral for Acupuncture Treatments

Patient's Name:_____ Date of Birth: _____

Condition(s) to be treated (description or ICD-10):

1. _____
2. _____
3. _____

Restrictions, if any, to be placed on the proposed treatment: _____

_____

Number of treatments and/or frequency of treatments: _____

Name of referring physician: _____

Address: _____

_____

_____

Phone number for consultation:

During normal business hours _____

After normal business hours _____

Email address _____

Signature: _____ Date: _____