

# ACUPUNCTURE REFERRAL FORM

\*(If required by your insurance company or requested by you or your physician.)

## Confidential health information

This transmission contains personal health information that you are required by law to maintain in a secure and confidential manner. Re-disclosure is prohibited. Failure to maintain confidentiality or re-disclosure without authorization could result in penalties as described in State and Federal law.

Referring Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

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## For Completion by Referring Physician:

I wish to refer my patient to receive acupuncture treatments.

Date of Referral: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Referral/Symptoms: \_\_\_\_\_

Diagnosis (if applicable) \_\_\_\_\_

ICD-10 code(s) \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Progress Report: verbally by patient end of treatment or per agreement.

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Phone: 330-830-3596/Fax: 330-833-7541

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