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:_____

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.

Acupuncture 8, LLC
Move Your Qi

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