Acupuncture Treatment Patient Referral Form

Date_____/_____/_____

Name of Patient_____ D.O.B. _____

Condition to be treated_____

Primary
Diagnosis_____

ICD-10 Diagnosis_____ICD-10 Code_____

Secondary Diagnosis_____

ICD-10 Diagnosis_____ICD-10 Code_____

Instructions or Precautions (if any):_____

_____

_____

Name of Referring Physician or Specialist_____

Address_____

Phone Number_____

Signature_____

Please return this form to:

Att: Sharmine Lynch, L.Ac.

Healing Care Acupuncture
105 W. North College Street, Suite 10
Yellow Springs, OH 45387
(937) 532-5773
www.HealingCareAcupuncture.com
medsnl@hughes.net