Advanced Acupuncture Center

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Physician's Referral for Acupuncture Treatments

Patient's Name _____Date of Request:____/_____/_____

Condition to be treated _____

ICD-9 Diagnosis Codes) _____._____, _____._____, _____._____

Intervals at which the patient's progress is reported of referring physician _____

Restrictions, if any, placed on proposed treatment _____

Name of referring physician _____

Address _____

Phone number for consultation during normal business hours _____

Phone number after normal business hours _____

Email Address _____

_____
Signature