



ACUPUNCTURE REFERRAL FORM

Date:
Patient Name:
Date of Birth:
Referring Physician:
Clinic Name:
Address:
Phone:
Fax:
Diagnoses/Reasons for Referral:
Date of Recent Medical Diagnostic Examination:
Results of Exam (Please elaborate or attach a report of results):
Please indicate any conditions or restrictions to treatments:
Signature of Physician:
Referred to: Gurneet M. Singh, <i>Registered Acupuncturist</i> Lotus Healing, LLC Triune 325 Cherry Street Philadelphia, PA 19106 Phone: (215) 627-6279 Fax: (215) 627-7244
PLEASE FAX COMPLETED REFERRAL FORM TO: 215-627-7244. A COPY OF THIS FORM WILL BE RETAINED IN THE PATIENT'S CHART. I APPRECIATE YOUR REFERRAL. THANK YOU.

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