wellness center

825 S. Main Street, Findlay, OH 45840 | **[P]** 419 427-9355 **[F]** 419 427-2902

ACUPUNCTURE REFERRAL

Date: _____ / _____ / _____

Patient Name: _____

_____

Primary Diagnosis: _____

_____

Secondary Diagnosis: _____

_____

Instructions/Precautions: _____

_____

Current Treatment: _____

_____

Referring Physician: _____

Physician Address: _____

City: _____ **State:** _____ **Zip:** _____

Physician Phone: (_____) _____ - _____ **FAX:** (_____) _____ - _____

Physician Signature: _____