Physician's Referral for Acupuncture Treatments

Patient's Name:______________________________ Date of Request: ____/_____/_____

Condition to be treated: ____

Name of referring physician: ____

Physician Address: ____

Physician Phone: ____

Email Address: ____

Instructions/Precautions: ____

____

Physician Signature

Melanie Campbell, L.Ac.

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