Bridges Family Wellness PC

Patient Referral

PATIENT INFORMATION:
Patient Name:

DOB: **Gender:** **Guardian Name:**

Patient Telephone: **E-mail:**

Patient Insurance company and identification number:

Please have your patient visit www.bridgesfamilywellness.com to schedule a visit.

Diagnoses:

Current Medications:

REASON FOR REFERRAL:
Check all that apply.

[ ] Craniosacral therapy
[ ] Psoriasis consultation
[ ] Herbal medicine consultation
[ ] Nutritional Consultation
[ ] Constitutional hydrotherapy
[ ] Hot fomentation hydrotherapy
[ ] Infrared sauna therapy
[ ] Medical consultation & treatment
[ ] Other

DETAILS:

CONTEXT OF CARE: We are mindful about respecting the intentions of the referring provider.

[ ] ONLY the treatment marked above
[ ] second opinion on the patient's condition/treatment options
[ ] ongoing management of: [ ] Naturopathic care [ ] Primary Care [ ] Other:

Referring Provider:

Signature:
Tel: Fax:

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