

Referral Form

Thank you for your referral and the opportunity to care for your patient!

Patient Information:

Name:	D.O.B.
Phone:	Diagnosis (if applicable):
Address:	Insurance:
City: State:	Policy #:
Zip:	<input type="checkbox"/> See Attached Face Sheet

Referring Physician Information:

Clinic:	
Phone:	Fax:
Physician:	Signature

Examinations/Evaluations:

<input type="checkbox"/> Primary Care Referral:
<input type="checkbox"/> Complete Naturopathic Evaluation Only
<input type="checkbox"/> Food Intolerance Evaluation (Carroll Method) Only

Results will be sent directly to patient unless specified otherwise

Naturopathic Hydrotherapy:

<input type="checkbox"/> Constitutional Hydrotherapy as indicated by PCNM Physician	Notes:
<input type="checkbox"/> Specific variation (specific organ support, diathermy, direct limb treatment, high frequency/violet ray, etc. Please add notes)	
# Treatments: _____	<i>Acute conditions require a minimum of 3-5 tx Chronic conditions require a minimum of 15-25 tx</i>

Other Treatments and Services:

<input type="checkbox"/> Acupuncture and/or Cupping Evaluation and Treatment	Notes:
<input type="checkbox"/> Pelvic Floor Physical Therapy	
<input type="checkbox"/> Craniosacral Therapy	
<input type="checkbox"/> Functional Nutrition Consultation	*Note* If the patient is not under care of a PCNM physician, we are unable to bill insurance. Rates are \$115 for new consults and \$50 for follow up consults.

Please attach any relevant clinical information (chart notes, labs, imaging, etc.):