

Referring Physician:

Address:

Phone:

Fax:

Physician Referral Form

Fax to: 231-668-7695

For Completion by Referring Physician:

I wish to refer my patient to receive acupuncture treatments.

Date of Referral: _____

Patient Name: _____

Patient Address: _____

Date of Birth: _____



Physician Signature: _____

Physician Printed Name: _____

Pathways Acupuncture

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