Pacific Clinic of Natural Medicine

Referral Form

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

Patient Information:

Name:	**D.O.B.**
Phone:	ICD-10:
Address:	Insurance:
City: State:	Policy #:
Zip:	☐ See Attached Face Sheet

Referring Physician Information:

Clinic:	
Phone:	Fax:
Physician:	Signature

Examinations/Consultations:

☐ **Primary Care Referral:**
☐ **Complete Naturopathic Evaluation**, treatment plan and recommendations
☐ **Food Intolerance Evaluation** (Carroll Method) Only *Results will be sent directly to patient unless specified otherwise*

Naturopathic Hydrotherapy:

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

Other Services:

☐ **Acupuncture Evaluation and Treatment**	Notes:
☐ **Pelvic Floor Therapy Evaluation and Treatment**	

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