Referral Form

I (patient's name),_____ am notifying New Leaf Integrative Medicine of the following:

___ **Yes** ___ **No** I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

___ **Yes** __ **No** I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

It is my responsibility and choice whether to follow this advice.

OR

___I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic pain

___ Smoking addiction

___ Weight loss

___ Alcoholism

___ Substance abuse

_____ _____

Patient Signature (required) Date