

# ACUPUNCTURE REFERRAL FORM

Referring Physician:

Address:

Phone:

Fax:

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**FAX to: 1-250-941-8778**

For Completion by Referring Physician:

I wish to refer my patient to receive acupuncture treatments.

Date of Referral: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Reason for Referral/Symptoms of Concern: \_\_\_\_\_

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Physician Signature: \_\_\_\_\_

Progress Report: none  verbally by patient  end of treatment

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**Dr. Sterling Desmond** *Dr.TCM, Reg. Acupuncturist*

*Main Clinic:*

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Phone: 250-941-8777

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Also: 180 B – Fern Road West

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**FAX to: 250-941-8778**