Physician Referral Form

Patient Name: (First) (Last)

Patient Date of Birth: Gender:

Patient Address:

City: (**Louisiana Residents Only**) (Zip Code)

Phone Number:

Patient email:

Is Patient currently or at any time been Veteran **OR** Federal Employee: **Yes** **No**

QUALIFYING MEDICAL CONDITION(S) (Please check)

Cancer	Severe Muscle Spasms	HIV Positive
Glaucoma	AIDS	Intractable Pain
Cachexia	PTSD	Seizure Disorders
Epilepsy	Parkinson’s	Muscular Dystrophy
Crohn’s Disease	Autism Spectrum Disorder	Multiple Sclerosis
Spasticity		

Dates of Treatment: TO

Types of Treatments:
As indicated above, I am referring the referenced patient for a consultation with The Healing Clinic, LLC based on current qualifying condition(s). Please attach pertinent medical records that confirm qualifying condition.

Physician Name:

Physician Address:

Phone #: Fax #:

Physician email:

Physician Signature: Date: