Physician Referral Form

Patient Name:____

Patient Date of Birth:__________________________________Gender:_____________________________________

Patient Street Address:____

City:____State_________________Zip Code:________________________

Patient Phone Number:____

Patient Email:____

DEBILITATING DIAGNOSES:____

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____

____

Date of Treatment:____to____

Types of Treatments:____

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*As indicated above, I am referring the referenced patient for a consultation with The Healing Clinics, LLC based on current debilitating condition(s).

Physician Name:____

Physician Address:____

Physician Phone Number:____

Physician Signature:____Date:__________________

Thank you for your referral! No additional medical records are needed at this time.

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Shreveport, LA 71104

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info@thehealingclinics.com Email

Form Revised
10/18/22