

REFERRAL FOR TREATMENT

Grand Traverse Natural Health Care

626 East Eight Street, Suite 17

Traverse City, Michigan 49686

phone 231.929.8183

www.gtnaturalhealth.com clinic@gtnaturalhealth.com



FAX TO: 231.929.8185

For Completion by Referring Physician:

Referring Physician _____ Phone _____

I would like to refer my patient,

Name _____ Date of Birth _____

Phone # _____

For Acupuncture Manual Massage Therapy

Frequency / Duration: _____ times per week _____ # of months

Diagnosis / Relevant History

Physician Signature _____ Date _____

FAX TO: 231.929.8185

Confidentiality Statement:

This fax and the materials contained within it may contain privileged or confidential information that is protected against use or disclosure under federal and state law. Use or disclosure of the contents of this fax by an unintended recipient is impolite and in some cases illegal. If you have received this fax in error, please so advise the sender by telephone or email as soon as possible and permanently dispose of the fax. Thank you for your cooperation.