



CONNECT HEALTH

CENTRE FOR
INTEGRATIVE MEDICINE

Referral Form for Acupuncture/Traditional Chinese Medicine

Date: _____

Referring Practitioner's Information

Name: _____

Phone: _____

Email: _____

Mailing Address: _____

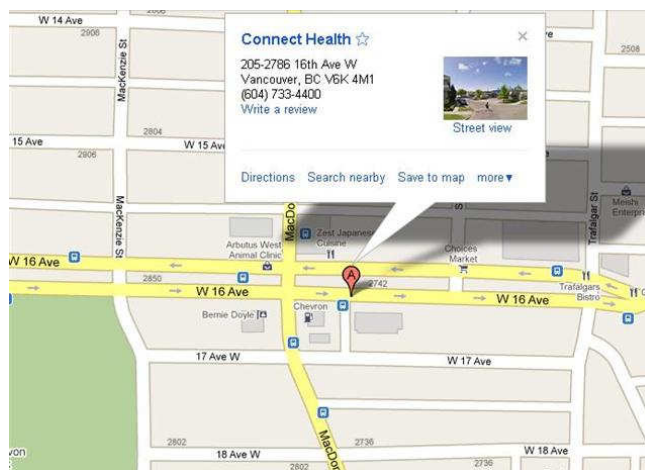
Would you like Dr. Carr to follow up with you?: Yes No

Patient Information

Name: _____

Diagnosis: _____

Notes: _____



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