ARIA INTEGRATIVE MEDICINE

Referral Form

Patient Information:

Name (Last, First, MI): _____

DOB: _____ **Phone:** _____

Please attach all patient demographic and clinical information (including H&P) specific to the patient's disorder.

Requested of:

- ☐ First available naturopathic physician/acupuncturist
- ☐ Kelly Baker, ND, Lac
- ☐ Jennifer Berg, ND, LAc

Suspected or Confirmed Diagnosis (one or more must be checked):

☐ 579.0 Celiac Disease	☐ 245.2 Hashimoto's Thyroiditis	☐ 714.00 Rheumatoid Arthritis
☐ 555.9 Crohn's Disease	☐ 340.00 Multiple sclerosis	☐ 710.10 Scleroderma
☐ 242.00 Graves Disease	☐ 696.1 Psoriasis	☐ 710.00 Lupus (SLE)
☐ Other _____		☐ 556.90 Ulcerative colitis

Do you want to transfer care of this patient? ☐ Yes ☐ No

Comments:

Referring Physician: _____ **Phone:** _____

Signature: _____ **Date:** _____

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