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.

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

- ☐ 720.0 Ankylosing Spondylitis
- ☐ 579.0 Celiac Disease
- ☐ 555.9 Crohn's Disease
- ☐ 250.81 Diabetes (type 1)
- ☐ 250.00 Diabetes (type 2)
- ☐ 242.00 Graves Disease
- ☐ 245.2 Hashimoto's Thyroiditis
- ☐ 340.00 Multiple sclerosis
- ☐ 696.1 Psoriasis
- ☐ 714.00 Rheumatoid Arthritis
- ☐ 710.10 Scleroderma
- ☐ 710.00 Lupus (SLE)
- ☐ 556.90 Ulcerative colitis

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

Other Services/Treatment Requested:

- ☐ Laboratory Testing
- ☐ Review of lab testing and treatment implementation
- ☐ Acupuncture/Chinese Medicine
- ☐ Specific Request _____
- ☐ Naturopathic Medicine

Comments:

Referring Physician: _____ **Phone:** _____

Signature: _____ **Date:** _____

3216 NE 45th Place, Suite 300
Seattle, WA 98105

Please Fax to Aria Integrative Medicine:
(206) 588-1227

Phone: (206) 588-1227
info@ariaintegrative.com
www.AriaIntegrative.com