Referral Form

Name	**Date**
Gender ☐ Male ☐ Female	
Phone Number	
Address	
Other ways of contacting (if applicable)	
Referred by	

Chronic Illness (check all that apply)	
☐ Anemia or "low blood"	☐ Angina or coronary heart disease
☐ Heart attack or myocardial infarction	☐ Congestive heart failure
☐ Dementia or "Alzheimer's"	☐ Diabetes or high blood sugar
☐ Liver disease or a bad liver or cirrhosis	☐ Hepatitis C
☐ Hepatitis B	☐ HIV/AIDS
☐ High cholesterol, lipids, or triglycerides	☐ Hypertension or high blood pressure
☐ Pancreatitis	☐ Bad circulation in your legs or feet
☐ Asthma	☐ Chronic lung disease (emphysema, chronic bronchitis, or COPD)
☐ Kidney failure (or bad kidneys)	☐ Stroke or "mini" stroke (Transient Ischemic Attack)
☐ Anxiety/Depression	☐ Bipolar disorder (Manic Depression)
☐ Post-traumatic stress disorder (PTSD)	☐ Schizo-affective/Schizophrenia
☐ Substance use disorder/addiction	☐ Alcohol use disorder/addiction
☐ Any kind of cancer	☐ Chronic pain
☐ Other (please specify):____________________________________	