The Healing Partnership

REFERRAL FORM

FAX TO (910) 833-8371

Client Name: _____

Date of Birth: _____ Phone Number: _____

Name and number of who is referring: _____

Is the client aware of this referral and expecting our call?_____

Insurance Coverage:_____

If the client has Medicare, do they have a secondary?_____

Diagnosis:_____

Reason for Referral:_____

Services Requested**:** □ counseling □medication evaluation

□massage □medical qigong □other_____

The Healing Partnership
2202 Wrightsville Ave Suite 211
Wilmington, NC 28403
(910) 833-8370 **(910) 833-8371 FAX**