Cavendish

Acupuncture Clinic

Acupuncture referral form *

Referring G.P / Healthcare professional _____

Address _____

Telephone _____

Email _____

For Completion by Referring G.P / Healthcare Professional:

I wish to refer my patient to receive acupuncture treatment.

Date of referral _____

Patient Name _____

D.O.B _____

Contact phone numbers _____

Including mobile if available _____

Reason for requesting acupuncture _____

Brief history of main relevant symptoms _____

_____

Previous medical history _____

Include HIV and hepatitis _____

Status if known _____

(Or attach printout)

Current medication _____

(Or attach printout) _____

**we accept personal referral letter giving the same information.*

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Member of the NHS Directory of Complementary & Alternative Practitioners.