

PATIENT INFORMATION

Name: _____ Phone #: _____

Date Of Birth: _____

Physician's Authorization Form for TCM Acupuncture

The above named patient is interested in receiving Traditional Chinese Medicine (TCM) Acupuncture at UW Health Integrative Medicine. Prior to initiating any treatments, the patient must have a physician's authorization for acupuncture. Please complete this form as thoroughly as possible for this patient.

1. Patient Precautions

- No restrictions or limitations for this patient.
 This patient has the following restrictions/limitations:

2. Physician Authorization

Physician Signature: _____ Date: _____

PRINT Physician Name: _____

Clinic Name & Address: _____ Phone: _____



Integrative Medicine

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(608) 263-7936

FAX, mail or deliver completed form to our front desk staff:

FAX
263-2215

Attn: **Front Desk**