LIFESTYLE h e a l t h

Physician Referral Form

www.lifestylehealth.co.nz

Tel: 09 550 6071 or 021 371 230
Email: lifestylehealth09@gmail.com

Patient Information ***(Must be fully completed)***

Name: ______________________

DOB: ______________________

Address: ______________________

NHI # ______________________

Tel: ______________________

1. **Referring Condition:**
   - Cardiovascular Disease, Chronic Fatigue Syndrome, Insomnia, Rheumatoid arthritis, Stroke, Depression, Fibromyalgia, Parkinson's Disease, Type 1 Diabetes, Type 2 Diabetes, Osteoarthritis, Impaired Glucose Tolerance, Obesity, Hypertension, Dyslipidemia, Cognitive Impairment, Dementia, Chronic low back pain

2. **Other Problems** *(Health Hx).*

3. **Prior Investigations**

   (please enclose relevant reports)

4. **Current Medications, Supplements or Treatments**

5. **Prior Consultations**
   (please indicate below and enclose relevant consultant's reports)

6. **Purpose of referral to Lifestyle health:**

Referring Physician Information *(Must be fully completed)*

Name: ______________________

Address: ______________________

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Tel: ______________________

Mob:: ______________________

Email: ______________________

Physician Billing Number: ______________________

Date: ______________________

______________________ MD