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## Patient Referral Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Referring Provider: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

### Evaluate

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Headaches    | <input type="checkbox"/> Musculoskeletal Pain  | <input type="checkbox"/> Osteoarthritis            |
| <input type="checkbox"/> Neuropathy   | <input type="checkbox"/> Disc Herniation/bulge | <input type="checkbox"/> Fibromyalgia              |
| <input type="checkbox"/> Sciatic Pain | <input type="checkbox"/> Knee Pain/OA Knee     | <input type="checkbox"/> Degenerative Disc Disease |

### Evaluate and Treat

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Stem Cell/<br>Regenerative Medicine | <input type="checkbox"/> Lumbar Decompression   | <input type="checkbox"/> Photobiomodulation<br>Laser                   |
| <input type="checkbox"/> Trigger Point<br>Injections         | <input type="checkbox"/> Cervical Decompression | <input type="checkbox"/> Pneumatic Compression<br>Boots for Neuropathy |
| <input type="checkbox"/> Peripheral Joint<br>Injection       | <input type="checkbox"/> Chiropractic Care      | <input type="checkbox"/> Monochromatic Lights for<br>Neuropathy        |

No medications are prescribed at our clinic.

We are working to reduce narcotic dependency within our community.

Thank you for your referral!

[www.loweryourpain.com](http://www.loweryourpain.com)