omaha integrative care
mind • body wellness

Omaha Integrative Care
Referral Request Form
Tel: 402-934-1617
Fax: 402-934-5228

Please fill in all requested data below and print and FAX with relevant clinical notes and a copy of the insurance card. Thank you!

Referrer Information:

Referring Provider: _____ _____ _____ _____
Last Name First Name Phone # Fax #

Specialty: _____ Provider Signature: _____

PCP (if different from above): _____ _____ _____
Last Name First Name Phone #

Patient Information:

☐ Female ☐ Male _____ _____ _____ _____
Last Name First Name MI DOB

_____ Referral Diagnosis: _____ ICD-10: _____
Phone #

Service Requested:

☐ Counseling ☐ Massage ☐ Integrative Health Consult ☐ Psychiatry

☐ Yoga ☐ Health Coaching ☐ Acupuncture ☐ Nutrition Counseling

Reason for Referral: _____

_____

Comments: _____

_____

Insurance Information:

Insurance Plan: _____ Insurance ID: _____

Form Completed by: _____ Phone Number: _____ Date: _____