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 (if applicable). 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 ☐ Other

_____ _____ _____ _____ _____
Last name First name MI DOB Phone #

Referral Diagnosis: _____ ICD-10: _____

Service Requested:

☐ Acupuncture ☐ Clinical Herbalism ☐ Centering Healthcare® ☐ Counseling/ Therapy

☐ Health Coaching/ Nutrition ☐ Integrative Health Consult ☐ Massage ☐ Meditation

☐ Psychiatry ☐ Psychological Testing ☐ Yoga

Reason for Referral: _____

_____

Comments: _____

_____

Insurance Information:

Insurance Plan: _____ Insurance ID: _____

Form Completed by: _____ Phone #: _____ Date: _____/_____/_____