Essence of China
Acupuncture & Herb Clinic

1717 West 86th Street
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Lei Shaw, L.Ac,
Dipl. Acupuncturist,
Dipl. Herbalist

Directions:

From the west:
Proceed east on 86th St. from Michigan Road. Pass the St. Vincent Hospital on our right. Turn right at Office Park Drive and then immediately make another right turn to enter the Professional Park. Turn left to enter the parking lot. Suite 120 is on your left.

From the east:
Proceed west on 86th St. from Meridian Street. Pass through the stoplight at Ditch Road. Turn left at Office Park Drive and then immediately make a right turn to enter the Professional Park. Turn left to enter the parking lot. Suite 120 is on your left.

Medical Practitioner Referral Order

Patient Name _____ D.O.B._____

Patient Telephone Number (_____) _____

As the referring PRACTITIONER for the above named patient please select the specialty treatment(s) indicated below:

- ☐ Acupuncture
- ☐ Chinese Herbs

Please Select Treatment for Condition(s) Indicated Below:

Pain management
___Headache (Migraine/ Tension/ Sinus) ___Fibromyalgia
___Pain and weakness in (Neck/Shoulders/Back/Abdomen/ Hips/Knees/Legs/Feet/ Hands)
___Muscle cramping ___Sprains, strains ___Sports injuries
___Arthritis ___Bursitis ___Disc problems
___Sciatica ___Carpal Tunnel ___Localized trauma

Neurological
___Facial Paralysis ___Trigeminal neuralgia
___Stroke rehabilitation (Paralysis/ Numbness/ Sensory loss/ Motor impairment)

Digestive
___Irritable bowel syndrome ___Gastric hyperacidity ___Chronic diarrhea
___Chronic constipation ___Bloating ___Nausea

Women's Health
___Irregular Menses ___Menopause ___Uterine fibroids
___Endometriosis ___Infertility ___Overactive bladder
___Morning sickness ___Postpartum recovery

Respiratory
___Sinusitis ___Common Cold ___Allergy
___Bronchitis ___Asthma ___Cough

Emotion
___Depression ___Anxiety ___Anxious

Other Conditions
___Smoking Cessation ___Insomnia
___Others, please specify: _____

Please Indicate Your Preferred Method of Follow-up:

___Phone: (_____)_____ -_____

___E-mail: _____@_____

___Fax: (_____)_____ -_____

___Mail: _____

Comments_____

_____

Referring practitioner (printed)_____ Date _____

Practitioner signature _____Telephone # _____

Please fax this form to (317) 334-0511