Uplift Health

Patient Referral

Thank you for choosing to refer your patient to Uplift Health MD. To start the referral process, please complete this form and submit it via fax or mail it directly to the clinic. Office address: 741 Kenmoor Ave. SE, Suite B, Grand Rapids, MI 49546. Fax number 616-226-4618. Send Attn: Dr. Zhiling Trowbridge.

You may also fax or mail brief, pertinent medical records, including test results and imaging, that support the consultation. For help referring a patient, call (616) 288-4931.

1. Please enter patient's information

First Name: _____ Last Name: _____ Date of Birth: _____

Gender:
- ○ Female ○ Male
- ○ Intersex
- ○ Transgender
- ○ Choose not to disclose

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email

2. Please enter referring office's information.

Name of Physician or Specialist _____ Office Name: _____ Street Address: _____ Apt./Unit #: _____

City: _____ State: _____ Work Phone: _____ Fax Number: _____

Zip Code: _____ Email: _____

3. Diagnosis/ICD-9/10

_____

4. Reason for referral?

_____

5. Requested service(s)?

☐ Integrative Medicine Consult ☐ Functional Medicine Testing ☐ Acupuncture

6. Other information you would like to provide?

_____

Notice of confidentiality

This is a confidential form and is intended solely for the person indicated above. If you are not the intended person, you are hereby notified of the confidential nature of this form and that you are not entitled to read, copy or otherwise disseminate any of the information contained herein.