

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 866-467-7702. 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) 899-9447.

1. Please enter patient's information

First Name:	Last Name:	Date of Birth:	Gender:	
_____	_____	_____	<input type="radio"/> Female <input type="radio"/> Male	
			<input type="radio"/> Intersex	
			<input type="radio"/> Transgender	
			<input type="radio"/> Choose not to disclose	
Street Address:	Apt./Unit #:	City:	State:	Zip Code:
_____	_____	_____	_____	_____
Mobile Phone:	Home Phone:	Work Phone:		
_____	_____	_____		
Email:	Preferred contact method:			
_____	<input type="radio"/> Mobile Phone <input type="radio"/> Home Phone <input type="radio"/> Work Phone <input type="radio"/> 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.