Life After **Mold**

Dr. Lauren Tessier
Naturopathic Physician
Mold Illness & CIRS Specialist
Shoemaker Certified Physician

Referral Form

Office Use Only
Date Received:_____
Date of Patient Contact:_____
Processed by:_____

Referring Physician
Physician Name:_____
Practice: _____
Address: _____
Phone: _____Fax: _____

Patient Details
Name:_____
Address: _____
How does the patient prefer to be contacted:_____
Email:_____
Phone (1): _____Phone (2):_____
Birthdate:_____Gender:_____
Language:_____

Pertinent Health Information
Briefly list the reason for the referrral:_____
_____
_____
_____
_____
_____
_____

To ensure a timely response, please check the boxes confirming the following (all are mandatory for referral):

I have included recent chart notes pertinent to the reason for referral……. ☐Yes ☐No

I have included all labs from the past year……. ☐Yes ☐No

I have informed the patient of this referral……. ☐Yes ☐No

I am willing to speak w/ Dr. Tessier if more information about the case is needed prior to scheduling……. ☐Yes ☐No

I understand that Dr. Tessier reserves the right to respectfully refuse a referral……. ☐Yes ☐No

Physician signature:_____**Date:_____**

Thank you for you interest in my practice and for your continued trust.
Your referrals are greatly appreciated.