Massage Therapy and Acupuncture Referral Form

Asa Acupuncture and Oriental Medicine
15935 NE 8th St Suite B200
Bellevue, WA 98008
Phone: (425) 246-1938
**ProviderOne # 215967501

Client's Name:_______________________________
Client's Date of Birth:_________________________
Month Day Year

Gender: ☐ M ☐ F ☐ Other (transgender/unspecified)

Address: ____

City: ______________________ Zip: _____________________

Phone #: _____________ Other #: ____________________

May we leave messages for you? ☐ Yes ☐ No

Best times to contact client? _____________________________

Emergency Contact: __________________________________

Phone#: _____________ Relationship: ___________________

Do you have limited proficiency in English? ☐ Yes ☐ No

Primary Language: ________________________

Preferred Language: ______________________

Do you need an interpreter? ☐Yes ☐ No

Have you ever had Massage or Acupuncture? ☐Yes ☐ No

Health Information

Client's Height: ______________________ **Client's Weight:**___________________________

Do you have allergies: ☐**Yes** ☐ **No** ____

Do you have any of the following: ☐**Yes** ☐ **No**

☐ Breathing difficulty	☐ Heart Issues	☐ Liver Disease
☐ Cancer	☐ Hypertension	☐ Multiple Sclerosis
☐ Chronic Illness	☐ Impaired Hearing	☐ Osteoporosis
☐ Chronic Pain	☐ Impaired Speech	☐ Parkinson's Disease
☐ Cognitive Issues	☐ Impaired Vision	☐ Psychological Issues
☐ Diabetes	☐ Kidney Disease	☐ Recent Fall/Injury/Surgery
☐ Gastrointestinal	☐ Limited Physical Mobility	☐ Stroke

☐ Other/Specify: ____

Services Requested

Authorization Number:___________________ **Authorized Service:**__________________________

Authorized Budget/Units:_________________ **Client Financial Responsibility :**_____________

Case Manager/Social Worker: _____________________ **Signature:**____________________________

Agency:________________ **Phone#:**____________________ **Email:**_____________________________

Notes____

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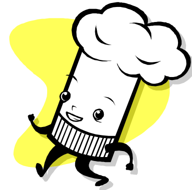
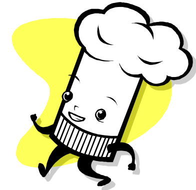
Authorization Process



1. Case Manager authorizes client's service/s.
2. Case Manager & Client complete referral form.
3. Email referral form via **Secure Email** to service provider.
4. Service Provider will contact client to schedule appointment.
5. Service Provider will email **Client Service Form** via **Secure Email** to case manager with appointment details.

Client Service Form



Service provider emails this completed form via "Secure Email" to client's case manager .

1. Authorization Number:____________________________________
2. Client's Full Name:____
3. Authorized Service:____
4. Authorized Budget/Units:____________________________________
5. Client Financial Responsibility:________________________________
6. Case Manager/Social Worker:_______________________________
7. Agency:____