



**BENJAMIN ZAPPIN, L.Ac.**

Acupuncture & Herbal Medicine

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## Acupuncture Referral

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

Insurance Policy # \_\_\_\_\_ Contact: \_\_\_\_\_

Member ID# \_\_\_\_\_

Treatments pre-authorized (# \_\_\_\_\_ of treatments)

## Treatment Plan

Frequency of Treatment: \_\_\_\_\_ treatment(s)/week for \_\_\_\_\_ weeks

Evaluate & treat as appropriate

Special instructions/precautions: \_\_\_\_\_

### Modalities/Procedures

Acupuncture

Electroacupuncture

Manual Therapy/Acupressure

Herbal Medicine

Dietary Therapy

**Referring Physician:** \_\_\_\_\_

Physician's Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Request a report