Meridian Naturopathic Clinic & Assessment Centre

Requisition for Assessment

Patient Information:

Name: _____ Phone #: _____

Address : _____

Referring Practitioner Information:

Doctor's Name: _____ Clinic: _____

Mailing Address: _____

Phone #: _____ Fax #: _____

Reason for Assessment or Areas of Concern :

_____

_____

Assessment Requested:

- ☐ Electro-dermal Testing (EDT)/ Acupuncture Meridian Assessment
  - ☐ I would like Meridian Clinic to provide remedies after testing.
    - *(We use natural homeopathic, herbal, and Chinese botanical remedies)*
- ☐ Live Blood Cell Analysis (LBCA)
- ☐ Computerized Regulation Thermography (CRT)

Results:

- ☐ Please check off how you prefer to receive results: ___via FAX, or ___via MAIL

Other SERVICES REQUIRED:

- ☐ First Line Therapy/ nutritional counseling
- ☐ Lymphatic Drainage
- ☐ Other (please specify below)

Comments:

_____

_____

_____

_____

Signature of Referring Practitioner

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