

**REFERRAL FOR TREATMENT**

8 Hearts Health & Wellness  
5331 SW Macadam Ave, Suite 380  
Portland, OR 97239  
Ph: 503-894-9118  
info@8hearts.org  
**FAX TO: 503-894-7398**



Referring Physician/Provider: \_\_\_\_\_ Provider Ph: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Ph: \_\_\_\_\_ Email: \_\_\_\_\_

Provider(s) requested:		
<input type="checkbox"/> Debroah Rice, ND	<input type="checkbox"/> Jason Wysocki, ND MS	<input type="checkbox"/> Steven Sandberg-Lewis, ND DHANP
<input type="checkbox"/> Dr. Roz Donovan, ND	<input type="checkbox"/> Josh Luper, LAc	<input type="checkbox"/> Kayle Sandberg-Lewis, LMT MA BCN

Service(s) requested:		
<input type="checkbox"/> Naturopathic medicine	<input type="checkbox"/> Homeopathic medicine	<input type="checkbox"/> Exercise counseling/therapy
<input type="checkbox"/> Structural Integration	<input type="checkbox"/> Mental Health	<input type="checkbox"/> GI/SIBO management
<input type="checkbox"/> Neurotransmitter support	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Neurofeedback

Health concern(s):			
<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Sleep/mood	<input type="checkbox"/> Weight	<input type="checkbox"/> Gastrointestinal
<input type="checkbox"/> Food allergies	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Endocrine (thyroid/hormonal)	<input type="checkbox"/> Women's medicine
<input type="checkbox"/> Skin	<input type="checkbox"/> Musculoskeletal pain	<input type="checkbox"/> Other	

Additional requests/comments/information regarding patient care:

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