GREEN WAVE FAMILY WELLNESS CENTER
625 Jenks Avenue Panama City, FL 32401
PanamaCityWellness.Com
Ph. 850-215-5657 Fax: 850-215-5658

REFERRAL FORM: referrals are considered to Dr. Chuck or Dr. Tali Cluxton and may be given to other appropriate licensed Green Wave staff based on best judgment unless practitioner noted here_____.

PLEASE CHECK SERVICES MEETING NEED FOR THE REFERRAL:

□ **Family Chiropractic** (Gentle spinal alignment and removal of Central Nervous System interferences)
□ **Therapeutic Massage** (Soft tissue work to relax, release and facilitate healing)
□ **Electronic Health Scan** (Electronic eval. of body systems, supplements & meds for insights)
□ **Weight Loss Program** **(**Determine weight gain cause and use natural means and advanced technologies for health
□ **Supplement Based Hormone Balancing (**Establishes healthy production and regulation via hormone nutrients)
□ **Infrared Sauna** **(**Healing effects of the sun without the ultraviolet. Spurring on health and cleanses the body)
□ **Detox and Weight Loss Body Wrap** (Use of a buffing cream, contour lotion, and body wrap to cleans and contour)
□ **Therapy/Counseling** (For more efficient establishment of life balance and psychosocial functioning)
□ Individual Therapy □ Family Therapy □ Couple/Marital Therapy
□ **Life Coaching** (Guidance to move to your next level of life balance and performance)
□ **Hypnotherapy** (Peaceful way to clear the past or change emotional engines going forward)
□ **Neuropathy Program** (Treatment for tingling, pins/needles or numbing and often swelling in hands or feet)
□ **Skin issues** (Treatment for concerns with the health, appearance, elasticity or sensitivity of the skin)
□ **Other** (_____)

Referring Doctor: _____ Date: _____

Signature of referring Doctor or authorized personnel: _____
Facility: _____
Address: _____
Office Phone: _____ Office Fax: _____

Referring Patient Information

Circle Account Type: PIP, LOP, Major Medical, Cash

Name: _____
Address: _____
_____
HM Phone: _____ Cell Phone: _____
DOB: _____ SS#: _____

Chief Complaint :(Circle-- PHYSICAL: Trauma or pain relating to Musculoskeletal, Headaches, Hormone imbalance, nutritional concerns/weight loss, neuropathy. PSYCHOLOGICAL concern of PTSD, Anxiety Reactions, Depressed Mood) Other: _____

_____

_____

Insurance Information

Primary Insurance name: _____
Insurance Address: _____
_____

Phone: _____Adjuster if known: _____
Claim #:_____ Policy#: _____
Date of Accident: _____ Attorney: _____

"Thank you in advance for the referral. We will inform you once our services are established."

7-10-16