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Referral to Dr. Andrew Bakken for chiropractic care

Back-In-Action
CHIROPRACTIC

Date: ____________________

Referring Physician:____

Phone #____________________________________Fax #_____________________________________

If you would like follow-up by mail, please provide a complete mailing address:

____

____

____

Patient Information

Last Name:__________________________________First Name:________________________________

DOB:______________________________________Phone #:__________________________________

Address:____

____

Diagnosis:____

Physicians Comments:____

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Thank you for allowing me to participate in your patient's care. My office will call the patient to get them scheduled for an appointment upon receiving your referral. If you have any questions, please do not hesitate to call me at 608-782-7738. I will send you an update with my clinical findings and treatment recommendations following the patients first appointment.

PLEASE FAX TO 1-833-259-4132

Back-In-Action Chiropractic S.C.
300 2nd Street N, Suite 220
La Crosse, WI 54601
ph: 608-782-7738 fax: 833-259-4132