

**NOTIFICATION FORM REGARDING EVALUATION OF PATIENT BY PHYSICIAN**

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name) \_\_\_\_\_, am notifying the acupuncturist Julie Luker, L. Ac. of the following:

Yes  No  I have been evaluated by a physician or dentist for the condition treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist.

\_\_\_\_\_ (initials of patient) Date: \_\_\_\_\_

OR

Yes  No  I have received a referral from a chiropractor within the last 30 days for acupuncture.

Date of referral: \_\_\_\_\_

Most recent date of chiropractic treatment: \_\_\_\_\_

After being referred by a chiropractor, if after 60 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility to follow this advice.

\_\_\_\_\_ (initials of patient) Date: \_\_\_\_\_

OR

I am seeking acupuncture treatment for one of the following conditions:

- Chronic Pain
- Smoking Cessation
- Weight Gain
- Substance Abuse

\_\_\_\_\_ (initials of patient) Date: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (required) Date

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The acupuncturist has referred me to a physician. It is my responsibility and choice to follow his/her advice.

\_\_\_\_\_  
Patient Signature (required ) Date

\_\_\_\_\_  
Acupuncturist's signature Date

Julie Luker, L. Ac. is not responsible for false statements made by patients.