Nurture Integrative Health Clinic
7175 SW Beveland Rd Suite 105
Tigard, OR 97223

Patient Referral Form

Referring Provider:_____

Phone Number: _____

Fax Number: _____

Patient Name: _____

Date of Birth:_____

Referral to Dr. Jennifer Karon, ND

- ☐ Hormones/Women's Health
- ☐ CranioSacral Therapy
- ☐ EDS/POTS evaluation
- ☐ Other _____

Referral to Dr. Kirstin Wilson, ND

- ☐ Neurology/Concussion Assessment
- ☐ Mold/Environmental Assessment
- ☐ CranioSacral Therapy
- ☐ EDS/POTS evaluation
- ☐ Other _____

Referral to Dr. LaKota Scott, ND

- ☐ Pelvic Floor Therapy
- ☐ Abdominal Therapy
- ☐ AFAB (Women's) Health Evaluation
- ☐ Other _____

Reason for Referral:

Please fax any pertinent chart notes and lab results to 503-506-0811.

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Authorization to Use and Disclose Medical Records

Please FAX this release form to:

Nurture Integrative Health Clinic

Attention: MEDICAL RECORDS

Phone: 503-244-0500 **Fax: 503-506-0811**

I _____ hereby authorize my confidential medical records
(name of patient/authorizing party)
to be released (faxed or mailed) to/from Nurture Integrative Health Clinic to ensure continuity of care. Please send the requested records to:

☐ Dr. Jennifer Karon ☐ Dr. Kirstin Wilson ☐ Dr. LaKota Scott

Patient's Name: _____

Date of Birth: _____ **Phone Number:** _____

Please release the following:

☐ Chart Notes ☐ Phone Consults

☐ Labs/Imaging ☐ Other _____

☐ All Records From Date: _____ to _____

Sign and date below:

_____ _____

Patient Signature Date