

# TEXAS ACUPUNCTURE CLINIC

## Notification Form Regarding Evaluation of Patient by Physician

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

I (patient's name), \_\_\_\_\_  
am notifying the Texas Acupuncture Clinic of the following:

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

**OR**

Yes \_\_\_ No \_\_\_ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is \_\_\_\_\_, and the most recent date of chiropractic treatment prior to acupuncture treatment is \_\_\_\_\_. After being referred by a chiropractor, if after two months 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 and choice to follow this advice.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
\_\_\_\_\_  
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

*The Texas Acupuncture Clinic is not responsible for untrue statements made by patients.*