Light of Grace
WELLNESS

Email or Fax/ Light of Grace will contact your patient to schedule within 1-2 business days.

REFERRAL FORM

Thank you for partnering with Light of Grace Wellness to support your patients.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____

City _____ State _____ Insurance _____

REASON FOR REFERRAL

- ☐ Bariatric Evaluations
- ☐ Individual Counseling
- ☐ Post Weight Loss Counseling
- ☐ Other: _____

REFERRING PROVIDER

Provider name: _____

Practice Name: _____

Phone: _____

Fax: _____

Email: _____

Date: _____

ADDITIONAL INFORMATION

_____

_____

_____

_____

Fax: 423-214-4624
Phone:423-837-7144
Lightofgracewellness.com
Youmatter@candicemilligan.com