



# Clean Colonic

## Referral Sheet for Procedure: Therapeutic Enema

Patient NAME \_\_\_\_\_ Date \_\_\_\_\_

2x a week for 12 weeks

OR Recommended Protocol: \_\_\_\_\_

**Diagnosis Code:** \_\_\_\_\_

**Referring Dr.** \_\_\_\_\_ **Phone#** \_\_\_\_\_

Any Questions please call or email.

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COMMENTS:

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