ODOM
HEALTH & WELLNESS

Patient's Name: _____ **DOB:** _____

Telephone: _____ **Email:** _____

Chief Complaint:

_____

Diagnosis:

_____

Odom Health & Wellness Services Recommended:

- ☐ Orthopedic Consultation - Dr. Odom
- ☐ Physical Therapy - Eval & Treat
- ☐ Platelet Rich Plasma Therapy (PRP)
- ☐ Prolotherapy
- ☐ Dry Needling
- ☐ Massage Therapy
- ☐ Personal Training
- ☐ Other: _____
- ☐ Therapies and Treatments at provider's discretion

Please provide specific recommendations and/or list any restrictions concerning this patient's present health status as it relates to this referral and subsequent treatment.

_____

_____

Please fax copies of any recent diagnostic imaging reports, physician's notes, patient demographics and insurance information along with this request form. Please fax this information to: **952-746-5655.**

Physician Name (Print): _____

Referring Physician's Signature: _____

Contact Telephone: _____ **Email:** _____

Address: _____