ODOM
HEALTH & WELLNESS

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

Telephone: _____ **Email:** _____

Chief Complaint:

_____

Diagnosis:

_____

Odom Health & Wellness Services or Therapies Recommended:

- ☐ Orthopedic Consultation - Dr. Odom
- ☐ Physical Therapy - Eval and Treat
- ☐ Platelet Rich Plasma Therapy (PRP)
- ☐ Prolotherapy
- ☐ Dry Needling
- ☐ Graston Therapy
- ☐ Massage Therapy
- ☐ Personal Training
- ☐ Medically Supervised Weight Loss
- ☐ Medical Nutrition Therapy/Counseling for:

  _____
- ☐ 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 procedures/therapies.

_____

_____

Please fax copies of any diagnostic reports (MRI, CT, X-Ray, etc.,) as well as the most recent physician's notes, patient demographics and insurance information related to the patient along with this request form. Please fax this form to: **952-746-5655**.

Physician Name (Print): _____

Referring Physician's Signature: _____

Contact Telephone: _____ **Email:** _____

Address: _____