Terrain Health

Next Generation Healthcare

Treatment Referral Order Form

Patient Name: _____ Date of Birth: _____

Ordering Physician: _____ NPI: _____

Ordering Physician Phone: _____ Diagnosis: _____

***Patient demographic sheet and recent blood work (within 6 months) including G6PD required with treatment order. Email documents to Asime@terrainhealth.org.**

Ozone Therapies

- ☐ EBOO-F
- ☐ Major Autohemotherapy (MAH)
- ☐ 10 Pass Ozone Therapy
- ☐ Vaginal Ozone
- ☐ Rectal Ozone

IV Therapies

- ☐ Antimicrobial
- ☐ Ascorbic Acid (Vitamin C)
- ☐ Cerebrolysin
- ☐ Chelation
- ☐ Curcumin
- ☐ Essentiale-N
- ☐ Exosomes
- ☐ Gut Health
- ☐ Homeopathy
- ☐ Iron
- ☐ Jumpstart
- ☐ Jumpstart Immune
- ☐ Methylene Blue
- ☐ Mineral Blend
- ☐ Myers Cocktail
- ☐ PK Push
- ☐ Plaquex
- ☐ PolyMVA
- ☐ Reseveratrol
- ☐ Saline

Integrative Therapies

- ☐ Airnergy Activated Oxygen
- ☐ Braintap
- ☐ Biomagnetic Therapy
- ☐ Hemealumen Polychromatic
- ☐ Hercules Multilaser
- ☐ Neural Therapy
- ☐ Ultraviolet Blood Irradiation

Order Notes (number of treatments, frequency, etc.)

_____

_____

_____

_____

_____

Ordering Physician Signature: _____ Date: _____