IV THERAPY REFERRAL REQUEST FORM

PATIENT INFORMATION

Patient Name: ☐ M ☐ F DOB: / /

Address: Phone Number:

REFERRING DOCTOR INFORMATION

Name of Referring Doctor:____

Name of Office/Facility:____

Address:_________________________ City:___________________________ State:_______

Phone:__________________________ Fax:_______________________________

REQUIRED LAB TESTING

In order to perform any of the IV therapies we require the blood testing below

Please contact our office if you would like help ordering your blood work. If testing is already complete please fill out the portion below and fax a copy of the results to our office at (925) 939-3181.

Have labs already been completed? Y N **If yes, when?** ____________

Please circle all tests that have already been performed below:

G6PD TSH CBC CMP

IV ORDER

Reason for referral/ treatment outcome / goal of therapy:

# of recommended treatments (frequency and duration)_____________OR ☐TBD by IV doctor at WCN

Vitality (IV vitamins&minerals)___ Immune Boost (extra Vit C, zinc, selenium)____ Rehydration _____
Malnutrition/Cachexia (with Amino Acids)______ High Dose Vitamin C____ Artesunate _____
Phosphatidylcholine (PTC) ____Hydrogen peroxide (H2O2)______ Glutathione____ Other_________

If you checked “Other,” please specify and provide the exact IV formula on a separate sheet:

****Please note that we require a 30 minute IV intake visit for all new IV patients at our clinic ****

Doctor Signature:____ Date: ______________

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