WALNUT CREEK NATUROPATHIC

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. Note, blood tests must be no more than **3 months old**, and depending on patient condition, we may require additional or more recent testing. 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

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 ____ Rehydration _____
Malnutrition/Cachexia (with Amino Acids)___ High Dose Vitamin C____ Artesunate _____
Phosphatidylcholine (PTC) ____ Major Autohemotherapy (MAH)_____ Chelation_____
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: _____