IV Therapy Referral Form

Please complete this form before the patient begins IV treatment.

INSTRUCTIONS

- Please complete this form before starting IV treatments.
- Fax the completed form and relevant lab results to 613-549-6565.
- Ongoing patient care is expected from the referring doctor.

REFERRING DOCTOR INFORMATION

Name _____ Clinic Telephone # _____

Practice Address _____ Clinic Fax # _____

PATIENT INFORMATION

Name _____ Age _____ Date of Birth _____

Home/Cell Telephone # _____

RECOMMENDED IV PROTOCOL

Check all that apply:

- ☐ Vitamin C
- ☐ Viscum Album
- ☐ Myers' Cocktail
- ☐ Immunity
- ☐ Glutathione
- ☐ Alpha-Lipoic Acid

Other _____

REQUIRED LAB RESULTS

- eGFR/Creatinine and liver panel - not older than 3 months.
- G6PD testing is required for IV Vitamin C.
- For supportive cancer care or kidney conditions: eGFR/Creatinine and liver panel must be retested every 3 months.

202-4 Cataraqui St, Kingston, Ontario | Tel: 613-549-7272 | Fax: 613-549-6565 | care@anamhealth.ca | anamhealth.ca

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Patient & Treatment Information

TREATMENT DETAILS

Frequency (treatments per week) and duration

Follow-up frequency with the patient

MEDICAL INFORMATION

Treatment rationale

Brief history of present illness

Possible contraindications to IV therapy

History of kidney stones? ☐ Yes ☐ No

Diabetes requiring home blood glucose monitoring? ☐ Yes ☐ No

CURRENT MEDICATIONS AND ALLERGIES

List all current medications, supplements, and other treatments

Any allergies (medications, foods, environmental)?

REFERRING DOCTOR AUTHORIZATION

Today's date

Referring doctor's signature

NEXT STEPS

- Patient will be notified and scheduled for an appointment.
- Administration will provide the necessary forms for the patient.

FAX COMPLETED FORM AND RELEVANT LAB RESULTS TO 613-549-6565

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