6839 FORT DENT WAY, SUITE 134, TUKWILA WA 98188 | PH: 206 812 9988 | FAX: 206 812 9989

Intravenous Therapy Referral

Contact Information

Patient Name: _____ DoB: _____ Patient Phone Number: _____

Prescribing Provider Name: _____ Provider License (ND*/MD): _____

Provider Phone Number: _____ Provider Fax Number: _____

**NDs, please provide a copy of your IV certification (located on the back of your license).*

IV Requested

[ ] Vitamin C Anti-viral (25 to 50 g Vitamin C, Minerals, B Vitamins) Dose: [ ] 25 grams, [ ] 50 grams

[ ] Vitamin C Drisko (25 to 100 g Vitamin C, Minerals) Dose: [ ] 25 grams, [ ] 50 grams, [ ] 75 grams, [ ] 100 grams

[ ] Myers Cocktail (5 g Vitamin C, Minerals, B vitamins)

[ ] Myers Short Anti-viral (5 g Vitamin C, Minerals, B Vitamins, Hydrochloric Acid)

[ ] Malnutrition (Amino Acids, Minerals, B Vitamins) Dose: [ ] Half (250mL total volume), [ ] Full (400mL total volume)

[ ] Malnutrition with Vitamin C (Amino Acids, Minerals, B Vitamins, Vitamin C)
Dose: [ ] Half (375mL total volume/10 grams Vitamin C), [ ] Full (550mL total volume/20 grams Vitamin C)

[ ] Trace Mineral (Minerals, B vitamins)

[ ] Heart/Plaque Chelation (Disodium EDTA) Maximum dose (always starts at 1500mg): [ ] 1500mg, [ ] 2250mg, [ ] 3000mg

[ ] Heavy Metal Chelation: [ ] EDTA only (3000mg), [ ] EDTA (3000mg) and DMPS (max. dose 250mg based on patient weight)

[ ] White Blood Cell Stimulation Push (Hydrochloric Acid)

[ ] Magnesium Push (3 grams)

[ ] Glutathione Dose: _____ (200mg to 3000mg)

[ ] Phosphatidylcholine Dose: _____(250mg to 1500mg)

[ ] Lipoic Acid Dose: [ ] 200mg, [ ] 300mg, [ ] 400mg, [ ] 600mg

[ ] Leucovorin Dose: _____ (Dossed in 5mg increments)

[ ] Sodium Chloride (hydration) ____ 250 ml ____ 500 ml ____ 1000 ml

[ ] UVBI (Ultraviolet Blood Irradiation; 150 to 300 cc blood treated)

[ ] Hyperbarric Ozone Therapy ("Single-Pass") (150 to 200 cc blood treated)

[ ] Therapeutic Phlebotomy _____cc (maximum 500cc removed) [ ] replace volume with equal amount of Sodium Chloride

[ ] Custom IV Formula (Please attach the formula you wish to be administered and we will let you know if we can do it.)

Frequency: _____ **Sessions per** _____ **(Week/Month/Year)**

Total Number of Treatments: _____

ICD-10 Code(s)/Diagnosis:_____

*** Please include a copy of recent CMP and CBC results. G6PD results are required for Vitamin C over 25 grams.**

Physician Signature: _____ **Date**: _____

For office use only:

□Labs Received □Order Approved □Patient Contacted