INTRAVENOUS THERAPY REFERRAL FORM

Please fill out and send to info@hillcresthealthcentre.com prior to having the patient book an initial IV Therapy appointment at Hillcrest Centre for Health. This form allows both practitioners to understand the therapy is being recommended and ensure that it is appropriate for the patient.

PATIENT INFORMATION

Patient Name: _____

DOB (Y/M/D): _____

Phone number: _____

Email: _____

REFERRAL INFORMATION

Referring Professional: _____

Office Address: _____

Phone number: _____ Email: _____

HEALTH GOALS

What are your goals for referring the patient for IV Therapy?

Has the patient ever received IV Therapy in the past?

Yes: _____ No: _____

Current Health Conditions

Brief history of the PRESENT health concern.

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Please list all MEDICATIONS (Including chemotherapy, if applicable) and NATURAL

SUPPLEMENTS that you are aware the PATIENT is currently prescribed (including dosages).

Does the PATIENT have any known ALLERGIES (food, environmental or drug) or "MEDIC ALERT" conditions?

Relevant Physical Examination

Please note any abnormal physical exam (vital signs - BP, HR, O2 sat, etc) findings here:

Review of Systems

Does the PATIENT require more than 15 grams of Vitamin C per treatment?

___ Yes. a G6PD test is required with this application if 15g of vitamin C is prescribed

___ No

For your patient to have IV Therapy, the following test results must be included with this application, or will need to be ordered before the first IV Therapy appointment:

___ Complete Blood Count (CBC), Liver Function Tests, Kidney Function Tests and Electrolytes

Parenteral Protocol

Please select your recommended IV Therapy:

___ Myer's Formula

___ Other (include formulation)

___ I would like Insight's IV practitioner to assess my patient and recommend an IV formula based on their complaints/conditions

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Recommended frequency of IV Therapy
___ 1x per week
___ 2x per week
___ 3x per week
___ 1 x per ____ weeks
___ Other: _____

Recommended duration of IV Therapy
___ < 4 weeks
___ 4 – 6 treatments
___ 6 – 12 treatments
___ 3 months
___ 6 months
___ Other: _____

Referral Policy.

This is an intra-professional referral and it will be at the discretion of the Naturopathic Doctor performing the IV to approve the treatment. While clinicians at Hillcrest Centre for Health will be fulfilling the duties of this referral, the referring doctor is expected to continue to provide ongoing care and management of the patient.

In completing the Intravenous Referral Form, the referring practitioner understands that they have initiated a referral for consultation and the specified IV therapy at Hillcrest Centre for Health with a certified naturopathic doctor. The Naturopathic Doctor and associated healthcare team involved in processing the referral is responsible for obtaining any additional information as required to schedule appointments and evaluate the patient (i.e. lab work, physical examination).

IV Therapy Referral Process

- **REFERRAL**: Complete IV Referral Form, including necessary physical exams, copies of relevant lab work and send to **info@hillcresthealthcentre.com** or fax to: 416-651-9058.
- **INITIAL IV VISIT** (approx. 15 minutes): After a brief history and physical exam, an introductory IV treatment will be provided. If the naturopathic doctor performing the IV determines a treatment that differs from the recommended protocol, the referring practitioner will be contacted to discuss any changes being made.
- **ONGOING CARE**: The therapy provided will focus on the health concern specified on the referral form. All other health concerns or changes to the patient treatment plan will be completed by the referring practitioner.

Referring Professionals signature: _____ Date: _____