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I, [prescribing physician], acknowledge a 30-minute complimentary consultation will be performed with my referred patient at Holistique Naturopathic Medical Center (HNMC) to ensure appropriateness and safety of IV infusion therapy. I confirm that the prescribed infusion therapy is safe for my patient, and that I will be providing follow-up care after completed treatments or as necessary. I have submitted all requested medical records and documents pertaining to my referred patient to HNMC. I understand the providers at HNMC may ask for clarification or refuse administration of the IV if they determine it to be unsafe for the patient.

I understand the following information needs to be received by HNMC prior to my patient being able to schedule prescribed treatments:

Demographics

Insurance

H&P relevant to Dx

G6PD (for an oxidative therapy)

Current medications

Intravenous & Intramuscular Injection Therapy Prescription

Contact Information

Patient Name: _____ DOB: _____ Patient Phone Number: _____

Prescribing Provider Name: _____

Provider License (ND/MD) And NPI: _____

Provider Phone Number: _____

Provider E-mail: _____

*Please note, we will require all new clients to complete a 30-minute complementary intake visit prior to initiating any IV therapy.

IV Nutrient Therapy Prescription

VITAMIN C DOSE: _____

Meyers Cocktail (5 grams Vitamin C, minerals, B vitamins including B Complex)

Venofer: DOSE: _____

NAD DOSE: _____

Glutathione DOSE: _____

Phosphatidylcholine DOSE: _____

Lipoic acid DOSE: _____

Mistletoe type, DOSE: _____

Custom IV DOSE: _____

IV Oxidative Therapy Prescription

UVBI AND OZONE (Ultraviolet Blood Irradiation; 60 cc blood treated) Ozone concentration: _____

Hemealumen AND OZONE (Full spectrum irradiation; approx 150 cc blood treated)

MULTIPASS HYPERBARIC OZONE THERAPY ("TEN-PASS") (up to 2000 cc blood treated under hyperbaric pressure)

Number of passes per treatment: _____

Hydrogen Peroxide: DOSE: _____

Frequency: _____ sessions per _____ (week/month/year)

NUMBER OF TREATMENTS: _____

IM Injection Nutrient Prescription

HYDROXYCOBALAMIN _____ mg

METHYLCOBALAMIN _____ mg

VITAMIN D3 _____ IU

IM INJECTION FREQUENCY: _____ Sessions Per _____ (Week/Month/Year)

Total Number Of Treatments: _____

Physician's Name: _____

Signature: _____

Date: _____