

Intravenous Nutrition Therapy Referral Form

Please fill out and send the form to info@evolve-massage.ca prior to having the patient book an IV appointment at Evolve Health and Wellness. If the Naturopathic Doctor requires further patient assessments prior to the IV treatment, the referring practitioner will be notified.

Patient name:

Referring professional:

DOB (M/D/Y):

Office Address:

Phone:

Office Phone:

Email:

Email:

Health Goals

What is your health goal(s) with IV therapy?

Has the patient received IV nutrition therapy before?

Yes

No

Current Health Conditions

Brief history of the PRESENT health concern (including any related health concerns)

Please list any medications (including chemotherapy, if applicable) and natural supplements that the patient is currently taking (include dosages).

Please list any known allergies, sensitivities, or “medic alerts”

Physical Examination

Has the patient had the following physical exams in the past (1) month?

- Vital Signs
- Cardiovascular
- Respiratory
- Peripheral vascular
- Abdominal
- To be done at first screening appointment

Please note any abnormal or relevant findings:

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

- Yes – G6PD test required with this referral
- No

The following tests must be included with this application or done prior to first IV therapy appointment. Tests results must be completed within 1 month from receiving this referral. Additional tests may be required depending on the patient's health history. Please include any other labs that may be helpful to support patient's treatment.

- Complete Blood Count
- Serum Creatinine/eGFR
- ALT
- Albumin

IV Therapy Protocol

Please select your recommended IV Therapy treatment:

- | | |
|--|--|
| <input type="checkbox"/> Meyer's Cocktail (energy and stress) | <input type="checkbox"/> Glutathione 1 gram |
| <input type="checkbox"/> Immune boost | <input type="checkbox"/> Glutathione 2 grams |
| <input type="checkbox"/> Athlete's Recovery | <input type="checkbox"/> Glutathione 3 grams |
| <input type="checkbox"/> Skin Glow | <input type="checkbox"/> Energize (fatigue, weight loss support) |
| <input type="checkbox"/> I would like Evolve's ND to assess my patient and recommend an IV formula based on their condition/complaints | <input type="checkbox"/> Other (please send formulation) |

Recommended frequency:

- 1x per week
- 2x per week
- 3x per week
- 1x per 2 weeks
- Other: _____

Recommended duration:

- <4 weeks
- 4-6 treatments
- 6-12 treatments
- 3 months
- 6 months

Referral Policy:

The IV treatment will be at the discretion of the performing ND to approve the treatment. While the Naturopathic Doctor at Evolve will be fulfilling the specific IV therapy at Evolve Health and Wellness, the referring practitioner is expected to continue to provide on-going 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 specific IV therapy at Evolve Health and Wellness with a Naturopathic Doctor. The Naturopathic Doctor and 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 the referral form including necessary physical exams, copies of relevant lab work and send to info@evolve-massage.ca or fax to 647-559-3712
- **Booking:** An IVIT screening form will be sent to the patient to complete prior to their IV screening appointment
- **Assessment visit:** Standard referral - 15 minutes, can be up to 45 minutes if the Naturopathic Doctor needs to assess further. The Naturopathic Doctor will review health history, complete any physical exams and discuss the IV process. If the Naturopathic Doctor performing the IV determines a different treatment that differs from the recommended protocol, the referring practitioner will be contacted to discuss any changes made.
- **On-going 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 Professional signature: _____ Date: _____