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	IV REFERRAL FORM			
Referring Practitioner	Office Ph	Office Phone #		
Practice name/location:	Emergenc	Emergency Phone #		
Reason for Referral				
Current Treatment				
□ Myer's Cocktail/Adrenal Fatigue/Stress IV □ Wound healing (pre/post surgery) IV □ De Athletic Recovery IV □ Glutathione IV/Push	etox/Liver Support IV 🗆 Diges	stive IV   Malnutrition	IV □ Prenatal IV □	
Duration of IV Treatments: G6PD test done?				
	PATIENT INFORMATION	ON		
Name	Today's Date:		Onto	
(Last name)	(First name)	10day 81	(mmm/dd/yyyy)	
Birthdate (M/D/Y):Age: _	Gender/Pronoun:	Health	Care #	
Address:				
Street	City	Province	Postal Code	
Phone:	E-mail: _			
Emergency contact info				
	ATIENT MEDICAL HIST	TOPV		
Brief history of Present Illness (including cor				
History of any of the following (Please circle	, indicate type and for how lor	ng):		
Decreased Kidney Function	Edema			
Kidney Disease/Condition	C			
Heart Disease/Condition		High Blood Pressure		
MI/Stroke CVD	High Ch	olesterol		
Last known Blood Pressure measurement: _ Please list current medications that your patie	ent has been prescribed:			
Any allergies or hypersensitivities to any of t				
Medicines:				
Environment:				
Other:				
Signature of Referring Practitions	er	License #		