nunm HEALTH CENTERS
Main Campus: 3025 S Corbett Ave. Portland, OR 97201
Fax: 503-226-8133 Referrals Phone:503-552-1959

Date Completed: _____

MRN: _____

DOB: _____

Referral for IV Therapy

Patient Information

Patient Name: _____Patient's DOB: _____Date: _____

Referring Provider and Contact Information (Phone & Fax #): _____

_____

Patient's PCP: _____

Referral Information

Goals of Treatment: _____

_____

_____

ICD-10: _____

Active Problem List and Current Medications: _____

_____

_____

Number of Treatments: _____ Frequency: _____ Duration: _____

IV Treatment Selection: *(Please check treatment choice(s)- cost varies)*

☐ Myers Push

☐ Myers Drip

☐ High Dose Vitamin C (25grams)

☐ High Dose Vitamin C (50grams)

☐ Glutathione Push

☐ Mini Drip: Nutrients, amino acids with Vitamin C

☐ Full Drip: Multi-nutrient Vitamin and Mineral with Vit C

☐ Rehydration IV Drip

☐ ALA

☐ IV treatment to be left up to discretion of the provider based on the patient's treatment goals and needs

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Labs: *(Include labs with referral)*

☐ CMP- please note- we need labs to be within 6 months old

☐ CBC - please note- we need labs to be within 6 months old

☐ G6PD- Needed for treatment with High Dose Vitamin C (HDIVC)- >5grams of Vitamin C

☐ EKG- Needed for IV Chelation, please send recent results (<1 month old)

* *Depending on the patient's condition and symptoms, labs may need to be performed sooner than 6 months*

Notes to Treating Provider:

_____

_____

_____

_____

Disclaimers:

Treatment is at the sole discretion of the supervising physician and treatment might be modified or denied if the supervising physician deems treatment to be unsafe or not needed.

Patient will need to schedule first for an IV consultation prior to administration of any IV treatments. This ensures that our patients are a good candidate for this type of therapy and to discuss treatment duration and costs.

Depending on the patient's condition and symptoms, labs may need to be performed sooner than 6 months and repeated during the course of treatment.

Referrals are only honored for a period of 90 days after which a new referral form will need to be completed.

Provider Signature:

Name (Print): _____ Phone: _____

Name of Practice: _____ Fax: _____

Signature: _____ Date: _____

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Please attach active Problem List, relevant Chart Notes, and Patient Demographics/Face Sheet
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