Ottawa Integrative Health Centre Inc.
Whole Family Healthcare ~ Naturally
(613)798-1000 • (E) info@oihc.ca • www.oihc.ca

# IV Referral Form

**Patient Information:**

Name:_____ Date:_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail: _____

Date of Birth: *Day* _____ *Month*_____ *Year* _____ Age _____

**Service Request:**

- IV **
- Other: _____

Dx: _____

Medical condition(s): _____

_____

_____

_____

_____

_____

Rx: _____

**Attached:**

- Physical Exam
- Recent Bloodwork
- UA
- G6PD (required for Vit C > 15g)
- GFR (required for Vit C > 15g)
- Other: _____

**Referring Physician's Name & Contact Information:**

_____

_____

*** Requires a 30 minute consultation with ND to discuss health history and ensure all blood work is complete before providing IV therapy.*

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# IV Referral Form

**Referring Physician's Name & Contact Information (cont'd.)**

_____

_____

_____

_____

_____

_____

Please attach any pertinent information regarding the health of the patient (recent lab work, reports, etc.).