insight
naturopathic clinic

INTRAVENOUS THERAPY REFERRAL FORM

Please fill out and send to **reception@insightnaturopathic.com** prior to having the patient book an initial IV therapy appointment at Insight Naturopathic Clinic. This form allows both practitioners to understand the therapy that is being recommended and ensure that it is appropriate for the patient.

Patient Name:	_____	Referring Professional:	_____
DOB (M/D/Y):	_____	Office Address:	_____
Home Phone:	_____	Office Phone:	_____
Contact Email:	_____	Contact Email:	_____

Health Goals

What is your goal(s) for referring the patient for IV Therapy?

Has the patient ever received IV Therapy in the past?

- ☐ Yes
- ☐ No

Current Health Conditions

Brief history of the PRESENT health concern (including concomitant health concerns):

Please list all MEDICATIONS (including chemotherapy, if applicable) and NATURAL SUPPLEMENTS that you are aware the PATIENT is currently prescribed (include dosages).

Does the PATIENT have any known ALLERGIES (food, environmental or drug) or “MEDIC ALERT” conditions?

Relevant 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 the first IV Therapy appointment

Please note any abnormal or relevant findings here:

Review of Systems

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

- ☐ Yes — a G6PD test is required with this application
- ☐ No

For your patient to have IV Therapy, the following test results must be included with this application, or needs to be done at the first IV Therapy appointment:

- ☐ Complete Blood Count (CBC) - must include with application
- ☐ Serum creatinine (within 1 month of this application date) - must include with application

Do you have any additional reports/ laboratory results that might be helpful?

- ☐ Yes — please include them with this application
- ☐ No

Parenteral Protocol

Please select your recommended IV Therapy:

- ☐ Myer's Formula (Energy, Stress)
- ☐ Immune Formula
- ☐ Glutathione (Detox)
- ☐ High Dose Vitamin C (25-75G)
- ☐ Anti-oxidant (Fertility, Anti-aging)
- ☐ Amino Acid Formula
- ☐ Hydration Formula
- ☐ Other (include formulation)
- ☐ I would like Insight's IV practitioner to assess my patient and recommend an IV formula based on their complaints/conditions

Recommended frequency of IV Therapy:

- ☐ 1x per week
- ☐ 2x per week
- ☐ 3x per week
- ☐ 1x per 2 weeks

Other: _____

Recommended duration of IV Therapy:

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

Referral Policy

This is an intra-professional referral and it will be at the discretion of the naturopathic doctor performing the IV to approve the treatment. While clinicians at Insight Naturopathic will be fulfilling the duties of this referral, the referring doctor is expected to continue to provide ongoing 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 specified IV therapy at Insight Naturopathic with a certified naturopathic doctor. The naturopathic doctor and associated 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 IV Referral Form, including necessary physical exams, copies of relevant lab work (Creatinine, eGFR, ± G6PD), and send to **reception@insightnaturopathic.com** or fax to: 416-322-0497

- **BOOKING**: Please provide the following to help us contact your patient: 1) A daytime phone number 2) Their email address. They will be sent an online IV Intake Form to complete prior to their appointment or upon arrival.

- **INITIAL IV VISIT** (approx. 60 minutes): After a brief history and physical exam, an introductory IV treatment will be provided. If the naturopathic doctor performing the IV determines a treatment that differs from the recommended protocol, the referring practitioner will be contacted to discuss any changes being made.

- **ONGOING 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 Professionals signature: _____ Date: _____