Vitality BioMed Infusion Referral Form

Email to: info@vitalitybiomed.com
PH: 403-300-1698
Fax: 403-538-6593

Referring Physician

Physician Name:_____ Signature:_____
Clinic Name:_____ Clinic Phone: _____
Email:_____ Fax:_____

By Signing this document, I acknowledge as the ordering Physician that I am responsible for any bloodwork or follow up appointments required after this infusion. Any adverse effects experienced by the patient will be reported to the referring physician.

Patient Information

Patient Name:_____ PHN:_____
Date of Birth:_____ Phone number:_____

Infusion Type

Iron Infusion Therapy ☐
Venofer ☐
Monofer ☐

Vitamin Therapy ☐
Energize ☐ Vitality ☐ Immune ☐
Detox ☐ Recover ☐ Migraine ☐
Slim ☐ Anti-Age ☐ NAD+ ☐
Vit C ☐ Lipids ☐ Ozone ☐

Bloodwork/Labs

Attach if required – If referring for Ozone IV Therapy, or Vitamin C 15G or more, G6PD test must be completed

History

Has the patient had past iron or vitamin infusions or injections Yes ☐ No ☐
Please Specify:_____
_____

Medications/Supplements:_____

_____

Allergies With Reactions

Drugs	Yes ☐	No ☐	Please Specify:_____
Sulpha Drugs	Yes ☐	No ☐	Please Specify:_____
Latex	Yes ☐	No ☐	Please Specify:_____
Adhesives	Yes ☐	No ☐	Please Specify:_____
Shellfish	Yes ☐	No ☐	Please Specify:_____
Iodine	Yes ☐	No ☐	Please Specify:_____
Others	Yes ☐	No ☐	Please Specify:_____

Medical History

Cardiovascular	Yes ☐	No ☐	Please Specify:_____
Respiratory	Yes ☐	No ☐	Please Specify:_____
Renal	Yes ☐	No ☐	Please Specify:_____
Endocrine	Yes ☐	No ☐	Please Specify:_____
Digestive	Yes ☐	No ☐	Please Specify:_____
Pregnant	Yes ☐	No ☐	Please Specify:_____
Breastfeeding	Yes ☐	No ☐	Please Specify:_____
Mental health	Yes ☐	No ☐	Please Specify:_____

Physician Prescription (Please attach if required):

Please include the following:

IV/Infusion Type:

Amount:

Number of IV's:

Frequency of IV's: