Vitality BioMed

Infusion Referral Form

Vitamin & nutrient IV therapy

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REFERRING PROVIDER

Provider name:	**Signature:**	
Clinic name:	**Clinic phone:**	**Fax:**
Email:	**Date:**	

By signing this form, I acknowledge as the ordering provider 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 provider.

PATIENT INFORMATION

Patient name:	**PHN:**
Date of birth:	**Phone number:**

INFUSION TYPE — VITAMIN / NUTRIENT THERAPY

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

ADD-ON NUTRIENTS

☐ L-Arginine	☐ N-Acetyl Cysteine	☐ L-Carnitine
☐ Biotin	☐ L-Glutamine	☐ L-Glycine
☐ L-Lysine	☐ L-Proline	☐ L-Taurine
☐ Additional saline	☐ Glutathione	☐ Magnesium

INJECTIONS

☐ Vitamin B12	☐ Extra Strong B	☐ MIC

BLOODWORK / LABS

Attach if required. If referring for Ozone IV therapy, or Vitamin C 15 g or more, a G6PD test must be completed.

HISTORY

Has the patient had past 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: _____

PRESCRIPTION (please attach if required — include the following)

IV / infusion type:	**Amount:**
Number of IVs:	**Frequency of IVs:**
Other information relevant for this patient:	