1200 116th Ave NE, Suite C. Bellevue WA. 98004
Voice/Text: 425-451-0404   Fax: 833-371-1483
www.holistique.com

I, [prescribing physician], acknowledge a 30-minute complimentary consultation will be performed with my referred patient at Holistique Naturopathic Medical Center (HNMC) to ensure appropriateness and safety of IV infusion therapy. I confirm that the prescribed infusion therapy is safe for my patient, and that I will be providing follow-up care after completed treatments or as necessary. I have submitted all requested medical records and documents pertaining to my referred patient to HNMC. I understand the providers at HNMC may ask for clarification or refuse administration of the IV if they determine it to be unsafe for the patient.

I understand the following information needs to received by HNMC prior to my patient being able to schedule prescribed treatments:

Demographics
Insurance
H&P relevant to Dx
G6PD (for an oxidative therapy)
Current medications

Intravenous & Intramuscular Injection Therapy Prescription

Contact Information

Patient Name: ___________________________ DOB: ________________ Patient Phone Number: _________________

Prescribing Provider Name: ____

Provider License (ND/MD) And NPI: ____________________________________

Provider Phone Number: _____________________________________

Provider E-mail:____________________________________

*Please note, we will require all new clients to complete a 30-minute complementary intake visit prior to initiating any IV therapy.

IV Nutrient Therapy Prescription

[ ] VITAMIN C DOSE: ___________

[.] Myers Cocktail (5 grams Vitamin C, minerals, B vitamins including B Complex)

[ ] Venofer: DOSE:___________

[ ] NAD DOSE: ____________

[ ] Glutathione DOSE____________

[ ] Lipoic acid DOSE: ____________

[ ] Mistletoe type, DOSE:___________

[ ] Custom IV DOSE: ____________

IV Oxidative Therapy Prescription

[ ] UVBI AND OZONE (Ultraviolet Blood Irradiation; 60 cc blood treated) Ozone concentration: _______

[ ] Hemealumen AND OZONE (Full spectrum irradiation; approx 150 cc blood treated)

[ ] MULTIPASS HYPERBARIC OZONE THERAPY ("TEN-PASS") (up to 2000 cc blood treated under hyperbaric pressure)

Number of passes per treatment: __________

[ ] Hydrogen Peroxide: DOSE________

Frequency: _______ sessions per _______ (week/month/year)

NUMBER OF TREATMENTS: _____

IM Injection Nutrient Prescription

[ ] HYDROXYCOBALAMIN ______ mg

[ ] METHYLCOBALAMIN ______ mg

[ ] VITAMIN D3 ______ IU

IM INJECTION FREQUENCY: _______ Sessions Per _______ (Week/Month/Year)

Total Number Of Treatments: _____

Physician's Name: ______________________

Signature: _____________________________ **Date: _________________________**