Holistique Medical Center

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Thank you for referring your patient to us.

I acknowledge this referral form will be reviewed by a Holistique provider 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 Holistique. I understand the providers at Holistique may ask for clarification or refuse administration of the IV if they determine it to be unsafe for the patient.

**** Please attach a complete list of allergies, current medications, most recent chart note and any relevant labs ****

**** For any oxidative treatments (High dose Vit C, ozone, or H2O2 tx) a G6PD lab result is required, please attach ****

I understand the enclosed referral form needs to be received by HMC prior to my patient being able to schedule prescribed treatments and what I am submitting is true and correct to the best of my knowledge:

Signature _____

Date: _____

****If you don't see the specific drug or nutrient in the referral form attached, please write a detailed order request below and we will do our best to accommodate.**

Intravenous Injection Therapy Prescription

Patient Name: _____ DOB: _____ Patient Phone Number: _____

Prescribing Provider Name: _____

Provider License (ND/MD/DO/ARNP) & NPI: _____

Provider Phone Number: _____ Provider Email:_____

Provider Clinic Address: _____

Provider Signature: _____ Date:_____

IV Nutrient Therapy Prescription

[ ] VITAMIN C DOSE: _____ grams
[ ] MYERS IV

- [ ] COCKTAIL (5 g Vitamin C, minerals, B vitamins including B complex)
- [ ] 'SPECIAL' (7.5 g Vitamin C, minerals, B vitamins)
- [ ] 'MODIFIED' (5 g Vitamin C, minerals, B vitamins; NO B complex)
- [ ] 'PLUS' (Myers IV as above plus amino acids)

[ ] VENOFER DOSE: _____mg
[ ] NAD+ DOSE: _____mg
[ ] METHYLENE BLUE: _____mg
[ ] GLUTATHIONE DOSE: _____ grams
[ ] ALPHA LIPOIC ACID DOSE: _____mg
[ ] HYDROGEN PEROXIDE

Frequency: _____ sessions per _____ (week/month) (PLEASE CIRCLE!)
NUMBER OF TREATMENTS: _____

IV Oxidative Therapy Prescription

[ ] UVBI AND OZONE (Ultraviolet Blood Irradiation; 60 cc blood treated)
Ozone concentration: _____
[ ] MAJOR AUTOHEMOTHERAPY (Full Spectrum Irradiation; approx 150 cc blood treated)
Ozone concentration: _____
[ ] MULTIPASS HYPERBARIC OZONE THERAPY ("TEN-PASS") (up to 2000 cc blood treated under hyperbaric pressure)
Number of passes per treatment: _____

Other Therapies

[ ] WEBER LASER LIGHT: INTRAVENOUS/INTERSTITIAL/TOPICAL COLORS: INFRARED/RED/YELLOW/BLUE/ULTRAVIOLET

Frequency: _____ sessions per _____ (week/month) (PLEASE CIRCLE!)
NUMBER OF TREATMENTS: _____