NOVA HEALTH
INTEGRATIVE MEDICINE

Naturopathic and Integrative Medicine
Located in Core Link Wellness Centre
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INTRAVENOUS THERAPY REFERRAL FORM			**Date of Referral:**	
Referring Practitioner:			**Patient Name:**	
Referring Practitioner Contact:	**Ph:**		**Date of Birth:**	
	Fax:		**Phone:**	
	Eml:		**Email:**	

*****ATTACH RELEVANT BLOOD TESTS, IMAGE REPORTS, LAB RESULTS, ETC…*****

Reason for referral:	
IV treatment requested:	
Current and previous medical diagnoses:	
Please specify any liver disease, kidney disease, lung or cardiovascular conditions.	
Current Supplements:	
Current Medications:	
Does the patient have recent CBC, Creatinine/eGFR, G6PD, etc.. Please attach copies.	

Please use a separate page if required