IV THERAPY REFERRAL FORM

TO BE FILLED OUT BY THE REFERRING PHYSICIAN

Natura Health And Wellness Clinic
1805 Bancroft
Missoula, MT 59801

PATIENT <u>MAY</u> BE SCHEDULED FOR A BRIEF INTAKE APPOINTMENT BEFORE THE IV CAN BE ADMINISTERED TO ESTABLISH CONTINUITY OF CARE AND DETERMINE PATIENT'S APPROPRIATENESS FOR IV THERAPY IN THIS OFFICE. INTAKE APPOINTMENTS AND IVs CAN TAKE PLACE ON THE SAME DAY. HEAVY METAL TESTING LIKELY WILL NOT NEED AN INTAKE APPOINTMENT.

REFERRAL INFORMATION

PATIENT REFERRED BY ______________________ TODAY'S DATE ______________

REFERRING DOCTOR PHONE ______________________ FAX ______________

PATIENT FIRST NAME ______________________ LAST NAME ______________

DATE OF BIRTH ______________ AGE ________ GENDER ______________

ADDRESS ____

CITY ______________________ STATE ________ ZIP CODE ______________

PHONE # (HOME) ______________________ (CELL) ______________

EMAIL ____

EMERGENCY CONTACT NAME ______________________ RELATIONSHIP ______________

EMERGENCY CONTACT PHONE # ____

PATIENT WILL CALL TO SCHEDULE Y / N **NATURA NEEDS TO CALL TO SCHEDULE Y / N**

IV PRESCRIPTION ____

FREQUENCY ____

NUMBER OF IVs BEFORE / OR DATE DATIENT IS TO FOLLOW UP WITH REFERRING PHYSICIAN ______________

____

REASON FOR REFERRAL – ICD-10 CODE ______________________

****DATE OF LAST CHEMISTRY SCREEN / ATTACH** ______________________

CURRENT HEALTH CONCERNS FOR WHICH IV IS BEING PRESCRIBED ______________________

____

____

MEDICAL HISTORY

ILLNESSES/CONDITIONS: check appropriate box, **YES** = current condition, **PAST** = a condition you've previously had

Condition			Condition		
CROHN'S DISEASE	☐ YES	☐ PAST	ANGINA	☐ YES	☐ PAST
GALLSTONES	☐ YES	☐ PAST	HEART ATTACK	☐ YES	☐ PAST
ASTHMA	☐ YES	☐ PAST	HEART FAILURE	☐ YES	☐ PAST
KIDNEY PROBLEMS	☐ YES	☐ PAST	HIGH BLOOD PRESSURE	☐ YES	☐ PAST
LIVER PROBLEMS	☐ YES	☐ PAST	LOW BLOOD PRESSURE	☐ YES	☐ PAST
DIABETES	☐ YES	☐ PAST	STROKE	☐ YES	☐ PAST
EPILEPSY/SEIZURES	☐ YES	☐ PAST	ARRYTHMIA	☐ YES	☐ PAST
SUDDEN WEIGHT LOSS	☐ YES	☐ PAST	ANKLE SWELLING	☐ YES	☐ PAST
CANCER	☐ YES	☐ PAST	BLEEDING DISORDER	☐ YES	☐ PAST

MOST RECENT CHEM PANEL ______________

EDTA OR DMPS REQUIRES CHEMISTRY PANEL OF NO MORE THAN 3 MONTH OLD (OR RENAL AND HEPATIC FUNCTION PANEL)

G6PD __________

HIGH DOSE VITAMIN C (GREATER THAN 5 GRAMS) REQUIRES G6PD SERUM TESTING

DETAILS AS NECESSARY REGARDING ABOVE DIAGNESES ______________________

____

____

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IS PATIENT PREGNANT? ____________________

HOSPITALIZATIONS & SURGERIES IN THE LAST 12 MONTHS: ________________________________

____

ANY MEDICAL DEVICES IMPLANTED IN PATIENT'S BODY? (Pacemakers, glucose pump, picc line, etc.)

____ ☐ YES ☐ NO

KNOWN HISTORY OF SIGNIFICANT EXPOSURE TO HARMFUL CHEMICALS OR HEAVY METALS? ☐ YES ☐ NO

IF YES: CHEMICAL NAME, LENGTH OF EXPOSURE, DATE:

____

MEDICATIONS & SUPPLEMENTS TAKEN REGULARLY:

MEDICATION/SUPPLEMENTATION	DOSAGE	FREQUENCY

PLEASE LIST ALL ALLERGIES (known and suspected): ☐ NO KNOWN ALLERGIES

ALLERGEN	REACTION

SPECIAL DIET? IF YES, WHAT: ____

REFERRING PHYSICIAN'S SIGNATURE: ____ DATE: ____________________