15 - 1860 appleby line burlington ontario L7L 0B7
905.332.2828 info@imbuir.ca imbuir.ca
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IV Treatment Referral Form
External Referrals

Dear Doctor:

This form must be completed by you and sent back prior to your patients appointment at Imbuir Naturopathic Medicine + IV Therapy.

Patient's Name	
Date of Birth:	
Patient's Telephone Number:	
Patient's e-mail:	
Brief History of Present Illness (including noncomitant health conditions):	
Referring Doctor's Name:	
Office Address:	
Office Telephone Number:	

Recommended Parenteral Protocol (check all that apply):

- ☐ Immune Formula
- ☐ Myers Cocktail
- ☐ Surgery/Recovery
- ☐ Vitamin C (low dose)
- ☐ Vitamin C (above 25 grams)
- ☐ Glutathione
- ☐ Other (Please provide details):_____

_____
_____
_____

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Recommended Duration of Parenteral Treatment:_____

For patient to have parenteral treatment, the following test results completed within 1 month of this application date must be included:

- Serum creatinine
- CBC
- Electrolyte panel
- AST/ALT

Does this patient require more than 25 grams of vitamin C per treatment?

- ☐ YES – A G6PD test is required (within 6 months of application date)
- ☐ NO

Please list any medications/supplements the patient is currently taking or has been prescribed to your knowledge:_____
_____
_____

Does this patient have any **allergies** (foods, medications, etc.) that you are aware of?

Today's Date:_____

Referring Doctor's Signature:_____

Dr. Agnes Matacz Lic 1732

_____

Dr. Andrea Kuzmiski Lic 1398

_____

Please provide this document along with any related IV therapy treatment records, lab results, and other relevant information. Submissions can be sent to our fax at 1-866-761-0129 or emailed to info@imbuir.ca.

The identified patient will be contacted upon acceptance of the required information to schedule an appointment. Intake and consent/privacy forms will be provided and must be filled out by the patient before beginning treatment at Imbuir Naturopathic Medicine + IV Therapy.