Holistique

IV Infusion Therapy Referral Form

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

PATIENT NAME _____

Referring Provider Acknowledgment & Consent

Thank you for referring your patient to us.

PRESCRIBING PROVIDER

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

Provider Phone _____ Provider Email _____

Clinic Address _____

PROVIDER ACKNOWLEDGMENT

I acknowledge this referral form will be reviewed by a Holistique provider to ensure the 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.

PROVIDER INITIAL _____

REQUIRED ATTACHMENTS

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

G6PD lab result required. For any oxidative treatments (high-dose Vitamin C, ozone, H_2O_2, Methylene Blue therapy) a G6PD lab result must be attached. REQUIRED

ATTESTATION

I understand the enclosed referral form needs to be received by Holistique Medical Center (HMC) prior to my patient being able to schedule prescribed treatments, and that what I am submitting is true and correct to the best of my knowledge.

_____ _____

Referring Provider Signature Date

If you don't see the specific drug or nutrient in the referral form, please write a detailed order request in the **Additional / Custom Order Request** section on the last page and we will do our best to accommodate.

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Patient Information & History

PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____

Gender at Birth _____ **Patient Phone** _____ **Email** _____

Address _____

ALLERGIES

List all known allergies & reactions _____

_____

MEDICATIONS

List all current medications & dosages _____

_____

RELEVANT DIAGNOSES & CONDITIONS

List relevant Diagnoses / ICD-10-CM Codes _____

List any major conditions (check all that apply):

- ☐ Cancer
- ☐ Hypertension
- ☐ Lyme disease
- ☐ Kidney disease
- ☐ Heart disease
- ☐ Dysautonomia / POTS
- ☐ Liver disease
- ☐ Autoimmune disease
- ☐ Pulmonary conditions

☐ Others: _____

If yes to any of the above, please explain _____

IV NUTRIENT THERAPY PRESCRIPTION

- ☐ **Vit C (ascorbic acid, non-corn)** DOSE _____ grams
- ☐ **Myers Cocktail** — 5 g Vit C, minerals, B vitamins incl. B complex
- ☐ **Myers Special** — 7.5 g Vit C, minerals, B vitamins
- ☐ **Modified Myers** — 5 g Vit C, minerals, B vitamins; NO B complex
- ☐ **Myers Plus** — Myers formula 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 *(circle)* **Number of Total Sessions:** _____

IV OXIDATIVE THERAPY PRESCRIPTION

G6PD lab required

- ☐ **UVBI and Ozone** — Ultraviolet Blood Irradiation; 60 cc blood treated
  Ozone concentration: _____
- ☐ **Major Autohemotherapy** — Full Spectrum Irradiation; 150–250 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: _____

Frequency: _____ sessions per week / month *(circle)* **Number of Total Sessions:** _____

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Other Therapies

☐ **Weber Laser Light**
Delivery (circle): Intravenous / Interstitial / Topical
Colors (circle): Infrared / Red / Yellow / Blue / Ultraviolet
Frequency: _____ sessions per week / month *(circle)* **Number of Total Sessions:** _____

☐ **Therapeutic Plasma Exchange** — with / without IVIG evaluation
Enclose the following lab results: CBC with Diff, Complete Chemistry, CRPhs, Immunoglobulin G, Ferritin, fibrinogen, iron panel.
Number of Total Sessions _____

☐ **Rectal Ozone Insufflation**
Ozone Concentration _____ mg/mL **Total** _____ mL **Number of Total Sessions** _____

☐ **Ear / Nasal Ozone Insufflation**
Ozone Concentration _____ mg/mL **Total** _____ mL **Number of Total Sessions** _____

☐ **Hyperbaric Oxygen**
Dose _____ **Frequency** _____ **Number of Total Sessions** _____

☐ **NanoVi**
Number of Total Sessions _____

☐ **EMSCULPT NEO**
Areas to be treated _____
Mode (circle): Function / Sculpt
How often _____ **Number of Total Sessions** _____

☐ **EMSELLA Chair** — 2x per week for 6 sessions
Number of Total Sessions _____

☐ **Cranial Sacral**
Number of Total Sessions _____

☐ **Ballancer Pro Lymphatic**
Area (circle): Upper / Lower / Both **Number of Total Sessions** _____

☐ **Acupuncture**
Number of Total Sessions _____

☐ **Massage**
Number of Total Sessions _____

☐ **Lymphatic Massage**
Number of Total Sessions _____

ADDITIONAL / CUSTOM ORDER REQUEST

If a specific drug or nutrient is not listed above, please write a detailed order request here.

Prescribing Provider Signature _____ **Date** _____