1200 116th Ave NE, Suite C. Bellevue WA. 98004
Voice/Text: 425-451-0404 Fax:425-462-8919
www.holistique.com

Referring Provider:____

We thank you for referring your patient to us. Kindly choose the most relevant option below.

For Washington State Licensed Providers

OPTION ONE:

I, [ ], acknowledge a 30-minute complimentary consultation will be performed with my referred patient at Holistique Medical Center (Holistique) 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.
I understand the following information needs to be received by HMC prior to my patient being able to schedule prescribed treatments:

Demographics
Insurance
H&P relevant to Dx
G6PD (for an oxidative therapy)
Current medications

Signature ____________________________

Date: ______________________

OPTION TWO:
I,[ ], am referring my patient to Holistique for IV therapy, evaluation, administration and management. I have submitted all requested medical records, relevant laboratory tests and documents pertaining to my referred patient to Holistique. I understand Holistique may submit a medical records request that must be fulfilled prior to my patient being able to schedule treatments.

Non-Washington State Providers Referring for IV Prescription, Administration and Management

I,[ ], am referring my patient to Holistique for the prescription, administration and management of the therapy indicated below. I I have submitted all

requested medical records, relevant laboratory tests and documents pertaining to my referred patient to Holistique. I understand the providers at Holistique require an in-person visit to establish an appropriate plan of IV/Wellness therapy for my patient if the patient lives outside of Washington state. I understand Holistique may submit a medical records request that must be fulfilled prior to my patient being able to schedule treatments.

Intravenous & Intramuscular Injection Therapy Prescription

Contact Information

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 COCKTAIL (5 g Vitamin C, minerals, B vitamins including B complex)

[ ] MYERS 'SPECIAL' (7.5 g Vitamin C, minerals, B vitamins including B complex)

[ ] 'MODIFIED' MYERS COCKTAIL (5 g Vitamin C, minerals, B vitamins; NO B complex)

[ ] 'MODIFED' MYERS 'SPECIAL' (7.5 g Vitamin C, minerals, B vitamins; NO B complex)

[ ] MYERS '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

[ ] GLYCYRRHIZIC ACID DOSE: _______ milligrams

IV Oxidative Therapy Prescription

*Please note, we will require all new clients to complete a 30-minute complementary intake prior to initiating ozone therapy.

[ ] UVBI AND OZONE (Ultraviolet Blood Irradiation; 60 cc blood treated) Ozone concentration: ______

[ ] HEMEALUMEN AND OZONE (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: _________

[ ] HYDROGEN PEROXIDE

Other Therapies

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

Frequency: _______ sessions per _______ (week/month/year)

NUMBER OF TREATMENTS: _____