CENTRE FOR COLLABORATIVE HEALTH | The Oakville Clinic

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REFERRAL FORM FOR INTRAVENOUS (IV) THERAPY

FAX this form and supporting documents to 905-849-6165

Please note that the clinic will contact the patient to set up an appointment date and time, and will also notify the referring doctor of these details.

Patient Information:

First Name: ___________________________ Last Name: _________________________

Date of Birth: __________________________ Phone: ____________________________

OHIP#: _________________________________ Gender: _____________

Doctor's Information:

Name: _____________________________________ Designation: ______________

Phone: __________________________ Fax: ______________________________

Date of Referral:

Reason for Referral:

Patient's Medical Information:	
Allergies	
Current Medications	
Current Supplements	
Past Medical History	

*Please attach any relevant labs/investigations to aid in the management of this patient. Note that if key pre-treatment labs have not been completed within the past 3-6 months, these will be ordered by CCH.

All patients will be seen by a CCH naturopathic doctor prior to the initiation of IV therapy for an assessment and physical examination. All IV procedures are administered by our IV-licensed NDs.

Referring Doctor's Signature: ____