*The Raphael Clinic of Maryland*

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# IV Therapy Referral form

Date _____

- ❑ **IV THERAPY ONLY (30m initial appt)**
- ❑ **ONGOING MANAGEMENT + IV THERAPY (90m initial appt)**

Patient Name _____

Patient DOB _____

Patient Diagnosis _____

Patient Contact Phone _____ Patient Contact Email _____

Referring Practitioner _____

Referring Practitioner Contact Phone _____

Referring Practitioner Contact Email _____

## IV Therapy Requested

Type of infusion: _____

Frequency of infusion: _____

More instructions: _____

_____

## Prior IV Therapy

What types of IV therapy has been used already, and in what amounts? _____

_____

_____

**Concomitant Illnesses:** _____

_____

_____

_____

**Medication/Supplements:** _____

_____

_____

_____

**Follow-up:**

- ❑ Patient will be following up with: _____
- ❑ Patient care is being transferred to The Raphael Clinic of Maryland

**Labwork being followed (tumor markers, NK/CD, etc):** _____

_____

_____

_____

***Any other concerns or information you'd like us to know??*** _____

_____

_____

_____

_____

_____

_____

*Please send records (including infusion protocols) to above email or fax*
*THANK YOU FOR YOUR REFERRALS!! PLEASE CONTACT US IF YOU HAVE ANY CONCERNS OR QUESTIONS*

_____