



IV VITAMINS REFERRAL FORM

1927 Ironoak Way, Oakville, ON, L6H 0N1

P: (905) 636-9387 | F: (905) 636-9388

PATIENT INFORMATION

Full Name: _____

Date of Birth: _____

Phone #: _____

Email Address: _____

Address: _____

City: _____ Province: _____

Postal Code: _____

HCN with VC: _____

GFR < 50 mL/min: Y N

Recent Blood Test Attached: Y N

Pregnant: Y N

Allergies: _____

Reason for referral:

Crohn's disease

Ulcerative colitis

Fibromyalgia

Chronic fatigue syndrome

Other: _____

REFERRING PHYSICIAN INFORMATION

Physician's Name: _____ License #: _____ OHIP #: _____

Clinic Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Clinic Phone #: _____ Clinic Fax #: _____ Clinic Email: _____

Physician's Signature: _____

Date: _____

Please fax completed forms to (905) 636-9388