

CanBridgeCare IV Therapy Referral Form

Comprehensive IV therapy administered by experienced registered nurses, providing patients with personalized treatment in a comfortable setting, with continuous nursing monitoring throughout.



Physicians receive detailed reports the same day.

E-mail: canbridgecare@gmail.com

Fax referrals to **289-570-0055**

Patient Information

Patient name: _____

Date of birth: _____

HC#: _____ Sex: _____

Cell phone number: _____

E-mail: _____

Physician Information

Physician name: _____

Office fax: _____

Date: _____

Signature: _____

Referral Type (Check all that apply)

- ☐ IV Hydration
- ☐ IV Myers' Cocktail
- ☐ IV Vit. C
- ☐ IV Glutathione
- ☐ IV Ondansetron

- ☐ IV Monoferic
 - ☐ 500 mg
 - ☐ 1000 mg
- ☐ IV Venofer
 - ☐ 100 mg
 - ☐ 200 mg

- ☐ IM Vit. B12
- ☐ IM Vit. D
- ☐ IM Ondansetron

Reason for Referral/Clinical Indication

Relevant Medical Information

Allergies:

Current Medication:

Relevant Medical Conditions:

Previous IV Iron Treatment

___ Yes ___ No

Date: _____

Previous Reaction:

Provider's Order/Recommendation

Please attach recent blood test results.

We will contact the patient directly to provide information about their appointment. For more information, contact us.