

York Home Care Inc.

(647) 207-9697
info@yorkhomecare.ca
https://www.yorkhomecare.ca/ivtherapy
10376 Yonge St, unit 106, Richmond Hill



IV THERAPY REFERRAL FORM

REFERRING PROVIDER INFORMATION

Referring Physician/Nurse Practitioner: Click or tap here to enter text.

Clinic / Hospital: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Fax: Click or tap here to enter text.

Signature:

Date: Click or tap to enter a date.

PATIENT INFORMATION

Patient Name: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Health Card Number: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Emergency Contact Name/Relationship: Click or tap here to enter text.

Emergency Contact Phone: Click or tap here to enter text.

MEDICAL HISTORY / DIAGNOSIS

Primary Diagnosis:

Past Medical Conditions:

- ☐ Cardiovascular disease
- ☐ Hypertension / Hypotension
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Diabetes
- ☐ Thyroid disorders
- ☐ Autoimmune disorders
- ☐ GI disorders
- ☐ Cancer
- ☐ Severe electrolyte imbalance
- ☐ Pregnancy (if applicable)
- ☐ G6PD deficiency (if high-dose Vitamin C used)
- ☐ Active infection/fever
- ☐ Other: Click or tap here to enter text.

York Home Care Inc. (647) 207-9697 info@yorkhomecare.ca <https://www.yorkhomecare.ca/ivtherapy> 10376 Yonge St, unit 106, Richmond Hill**IV THERAPY REFERRAL FORM****Allergies (medications/food/other):** Click or tap here to enter text.**Current Medications:** Click or tap here to enter text.**Lab Work Required (if any)**Copy of blood work is attached YES ☐ No ☐

Date of Most Recent Labs: Click or tap to enter a date.

IV THERAPY ORDERS**Type of Therapy Required (check all that apply):**

- ☐ IV Hydration
☐ IV Antibiotics
☐ IV Electrolyte Replacement
☐ IV Vitamin Therapy
☐ IV Medication (specify): Click or tap here to enter text.
☐ Other: Click or tap here to enter text.

IV Prescription by provider: Click or tap here to enter text.**Priority:** ☐ Routine ☐ Urgent ☐ Stat**ADDITIONAL INSTRUCTIONS**

Click or tap here to enter text.

Referring Provider Signature: _____**Date:** _____**Signature:** X