Revolutions Naturopathic

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IV Referral Protocol

Section A.

Referring Provider Information:

Name: _____ License #_____ DEA#_____

Phone: _____ Email: _____

Practice Name and Address: _____

Patient Information:

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

____ This is a Specialist Referral (mark if you would like Revolutions Naturopathic Doctors to formulate treatments)

____ This is an IV Administration Referral ONLY (Please complete Section B)

Section B.

Frequency of Treatments: _____ Administration Rate(ggt/s):_____

IV Carrier Solution: (Check one)

☐ 250mL Sterile water ☐ 500mL Sterile water ☐ 1000mL Sterile water ☐ 500mL Half Normal saline (0.45%)

☐ 50mL Normal saline (0.9%) ☐ 100mL Normal saline (0.9%) ☐ 250mL Normal saline (0.9%) ☐ 500mL Normal saline (0.9%)

☐ 250mL Lactated ringers ☐250mL D5W ☐500mL D5W

IV Injectables	Volume (CC's)	Push	IV Injectables	Volume (CC's)	Push
Acetyl L-Cysteine (100mg/mL)			Lidocaine (1%)		
✝ Alpha-Lipoic Acid (25mg/mL)			Lysine (100mg/mL)		
Aminosyn II (8.5%)			Magnesium Chloride 200mg/mL)		
Ascorbic Acid (500mg/mL)			Manganese Chloride (2mg/mL)		
B-Complex (100mg/mL)			Methylcobalamin (5mg/mL)		
Biotin (10mg/mL)			MIC (25/50/50mg/mL)		
Calcium Chloride (10%)			Molybdenum (250mcg/mL)		
Dexpanthenol (250mg/mL)			MSM (100 mg/mL)		
Dextrose (50%)			Phosphatidyl Choline (50mg/mL)		
DMPS (50mg/mL)			✝ Poly-MVA		
✝ DMSO (99%)			Potassium Chloride (2mEq/mL)		
EDTA-Calcium (300mg/mL)			Procaine (2%)		
EDTA-Disodium (150mg/mL)			Pyridoxine (100mg/mL)		
Folic Acid (10mg/mL)			Selenium (200mcg/mL)		
Glutathione (200mg/mL)			Silver Hydrosol (60 ppm)		
Glycine (25mg/mL)			Sodium Bicarbonate (8.4%)		
Glycyrrhizic Acid (8mg/mL)			Taurine (50mg/mL)		
Heparin (5,000 USP)			Thiamine (100mg/mL)		
Hydrochloric Acid (2mg/mL)			Zinc Chloride (10mg/mL)		
Hydrogen Peroxide (3%)					

✝2 weeks' notice required as these materials are not always in stock.

Autohemotherapy: **Ozone** **Required:* *CC's Ozone _____ *Gamma _____ **UBI** ☐Yes

*CC's Blood _____ ☐No

We reserve the right to adjust treatment per safety and discretion of administering doctor.

IMPORTANT: If patient requires alternating treatments, please complete a separate referral form for each administration protocol.

☐ Check if **two or more** protocols are included # of Protocols _____

Section C.

Additional Instructions:_____

_____

_____

Doctor's Signature_____ Date_____