CIM | CASCADE INTEGRATIVE MEDICINE

450 NW Gilman Blvd, Ste 201
Issaquah, WA 98027
P: (425) 391-5270 | F: (425) 391-8091

IV Therapy Referral Form

Patient

Name: _____ DOB: _____

Address: _____

City, state, zip: _____

Cell: _____ Home: _____

Diagnosis(es): _____

Medications/supplements: _____

_____

Allergies: _____

Referring Physician

Provider name: _____

Clinic name: _____

Address: _____

City, state, zip: _____

Phone: _____ Fax: _____ Email:_____

IV Protocol

Venofer (iron sucrose) dosage: ☐ 100mg ☐ 200mg

Duration: once per week for ____ weeks

*Labs required: CBC, iron, ferritin, TIBC, and liver enzymes

Physician signature: _____ Date: _____

Please fax this form along with labs and chart notes to (425) 391-8091