Oncology for IV/IM Form

To: Renew IV Infusion	From: Oncology Provider

Client Name: _____Phone: _____

Sex: _____ Age: _____ DOB: _____

Address:_____

Your patient is requesting a service offered by Renew IV Infusion. Because of your client's diagnosis/health history, we ask Renew customers to discuss this with their physician and have their physician sign off on our treatments listed below. We require this to keep patients safe and to ensure they do not have underlying pathology that can affect the delivery of services.

Provider, please indicate what Renew services the client may receive:

□ IV Fluids (We allow 1-2 L/week for healthy individuals) Indicate other volume limits:_____

□ Prefer Lactated Ringers

□ Prefer Normal Saline

□ Intramuscular (IM) Vitamin Micronutrient Administration (See micronutrient list below)
□ IV Infusion rate. Typical infusion is 1L NS or LR over 60-90 min.

_____

_____

Provider Response:
□ No special precautions for IV/IM Therapy

Micronutrient List (Subject to Change) - Ascorbic Acid, B-6, B-5, B12, B-Complex, BCAA, Biotin, Calcitriol, Multi-Trace Minerals, Glutathione, L-Glutamine, L-Carnitine, Lipo, Lipo-C, Magnesium Sulfate, L-Proline, L-Lysine, Taurine, CoQ10

□ Other Notes and Considerations:

_____

Provider Name: _____
Provider License State/Number (Must be licensed in the state Renew is administering):

_____

Provider Signature: _____Date:_____

Services offered by Renew IV Infusion can be found on www.renewivinfusion.com