



# Referring Provider Order Form

<b>Hydrate Location:</b> _____	<b>Hydrate Email:</b> _____
--------------------------------	-----------------------------

**Client Information:**  
 Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date & Reason of Last Visit to Provider: \_\_\_\_\_

**Ordering Provider Information:**  
 Provider Name: \_\_\_\_\_ Practice: \_\_\_\_\_  
 Specialty: \_\_\_\_\_ License # & State: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_

This patient is requesting a service offered by our wellness spa (IV therapy, Vitamin Injections, or NAD+). Based upon the health history that the patient provided to us, we are requiring medical clearance for our services. Please review and select the services your patient may receive based upon your assessment of health history, medications and exam. **Please attach any supporting documents including chart notes and lab work and additional prescription as necessary.**

Provider, please select the services the patient may receive:

IV Therapy:	Injection Therapy:	NAD+ Therapy:
<input type="checkbox"/> 0.9% Normal Saline 500ml IV <input type="checkbox"/> 0.9% Normal Saline 1L IV <input type="checkbox"/> Amino Acids 1ml IV <input type="checkbox"/> B Complex 1ml IV <input type="checkbox"/> Calcium Gluconate 200mg IV <input type="checkbox"/> Calcium Gluconate 400mg IV <input type="checkbox"/> Dexpanthenol (B5) 250mg IV <input type="checkbox"/> Glutathione 500mg IV <input type="checkbox"/> Glutathione 1,000mg IV <input type="checkbox"/> Glutathione 1,500mg IV <input type="checkbox"/> Glutathione 2,000mg IV <input type="checkbox"/> Glutathione 2,500mg IV <input type="checkbox"/> L-Lysine 100mg IV <input type="checkbox"/> Magnesium Sulfate 500mg IV <input type="checkbox"/> Magnesium Sulfate 1000mg IV <input type="checkbox"/> Methylcobalamin (B12) 1mg IV <input type="checkbox"/> Pyridoxine (B6) 100mg IV <input type="checkbox"/> Vitamin C 2,500mg IV <input type="checkbox"/> Vitamin C 5,000mg IV <input type="checkbox"/> Vitamin C 7,500mg IV <input type="checkbox"/> Vitamin C 10,000mg IV * <input type="checkbox"/> Vitamin C 25,000mg IV * <input type="checkbox"/> Vitamin C 50,000mg IV * <input type="checkbox"/> Vitamin C 75,000mg IV * <input type="checkbox"/> Zinc 1mg IV <input type="checkbox"/> Zinc 5mg IV <input type="checkbox"/> Zinc 10mg IV <input type="checkbox"/> Toradol 15mg IV * (BMP or CMP lab required) <input type="checkbox"/> Zofran 4mg IV *	<input type="checkbox"/> Amino Acids 1ml IM <input type="checkbox"/> Glutathione 500mg IM <input type="checkbox"/> L-Lysine 100mg IM <input type="checkbox"/> Methylcobalamin (B12) 1mg SQ <input type="checkbox"/> MIC (Methionine, Inositol, Choline, B12) 1ml IM <input type="checkbox"/> Tri Immune (Vitamin C, Glutathione, Zinc) IM <input type="checkbox"/> Vitamin D3 50,000IU IM <input type="checkbox"/> Toradol 15mg IM * (BMP or CMP lab required) <input type="checkbox"/> Zofran 4mg IM * <input type="checkbox"/> Other (vitamin/dosage/frequency)*: _____ _____ _____	<input type="checkbox"/> NAD+ 250mg IV <input type="checkbox"/> NAD+ 500mg IV <input type="checkbox"/> NAD+ 750mg IV <input type="checkbox"/> NAD+ 1000mg IV <input type="checkbox"/> NAD+ 100mg SQ <input type="checkbox"/> NAD+ 150mg SQ <input type="checkbox"/> NAD+ 200mg SQ <input type="checkbox"/> Other _____

**Provider Specify:**

<input type="checkbox"/> Cleared for Injection Therapy ONLY	<input type="checkbox"/> Detailed Prescriptions for Asterisk Items Required and Attached
<input type="checkbox"/> Lab work/Supporting Documents Attached	<input type="checkbox"/> Other Please Specify: _____

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

These statements have not been evaluated by the FDA. This product is not intended to diagnose, treat, cure, or prevent any disease. This service is intended only for healthy adults. We do not offer services to minors under the age of 18 or pregnant women. We ask that clients who have tested positive for COVID-19 or have a fever stay home and we kindly ask clients who are not feeling well or exhibiting flu like symptoms to wear a mask while in our spas. Our team reserves the right to refuse service at any time. All services ordered by a referring provider need to be approved and are at the discretion of Hydrate IV Bar's Medical Director. Additional information may be required.