CONCIERGE NURSE SERVICES

P: (206)-486-4102
F:360-282-0126

IV Therapy: High Dose Vitamin C

Referral Form

Patient Information:

Name: _____ Date of Birth: _____

Phone Number: _____

Diagnosis(es): _____

_____

Referring Physician:

Provider Name: _____

Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

IV Protocol:

Ascorbic Acid Dosage (in Grams): _____

Duration: _____ (times per week) for _____ week(s)

I attest that the following lab work has been completed and is within appropriate limits to administer this high dose vitamin C protocol (results attached if available): ☐ G6PD ☐ Kidney Function Panel ☐ CBC ☐ BMP

Infusions will be mixed in 1000ml Sterile Water and infused up to 2.5 hours unless requested otherwise.

If the patient has a central line, does Concierge Nurse Services have permission to access and flush the line with a Heparin flush post-infusion? ☐ Yes ☐ No

Physician signature: _____ Date: _____

Concierge Nurse Services recommends the Riordan Protocol of 0.5mg/kg for High Dose Vitamin C infusions. Doses of 87g or higher require infusion via a central line.

Please fax this form and any Lab work to 360-282-0126