

PATIENT IV ORDER

(INTERNAL USE ONLY)

Patient Name: _____

D.O.B.: _____ Phone: _____

Diagnosis: _____

IV PROTOCOL

- | | | |
|--|---|---|
| <input type="checkbox"/> Best IV Ever | <input type="checkbox"/> Lyme I | <input type="checkbox"/> Pain / Insufflation |
| <input type="checkbox"/> Chelation | <input type="checkbox"/> Lyme II | <input type="checkbox"/> Paul Anderson AA |
| <input type="checkbox"/> Classic Myers | <input type="checkbox"/> Lyme III | <input type="checkbox"/> Phosphatidyl Choline |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme IV | <input type="checkbox"/> Silver |
| <input type="checkbox"/> Ghen Autoimmune | <input type="checkbox"/> Mac Degeneration | <input type="checkbox"/> Small Chelation |
| <input type="checkbox"/> H ₂ O ₂ | <input type="checkbox"/> Malabsorption | <input type="checkbox"/> UBI/MAH |
| <input type="checkbox"/> HCL | <input type="checkbox"/> Migraine | |
| <input type="checkbox"/> House Special | <input type="checkbox"/> Minerals | |

Dosage: _____ Frequency: _____

IV ADDITIVES

- | | | |
|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Amino Acids | <input type="checkbox"/> DMSO | <input type="checkbox"/> MSM |
| <input type="checkbox"/> B12 | <input type="checkbox"/> Glutathione | <input type="checkbox"/> Procaine (2%) |

Dosage: _____ Frequency: _____

Notes: _____

Ordering Provider: _____

Signature: _____ Date: _____

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