Vitamin and IV Therapy Script Form

Clinic Name	
Address	
Phone	

Prescriber		NPI/DEA	

☐ New Patient (if new, please include address and phone number with DOB)
☐ Existing Patient (if existing, only DOB required unless information changed)

Patient Name		DOB	

Patient Address	
Patient Phone	

Allergy: _____

☐ Ship to Clinic	☐ Ship to Patient	☐ Pick-up	☐ Bill Patient	☐ Bill Clinic

Drug Name	Size	Strength
☐ ***ALPHA LIPOIC ACID***	5mL	25mg/mL
☐ ***GLUTATHIONE***	10mL	200mg/mL
☐ ***L-CARNITINE***	5mL	250mg/mL
☐ ***NAD+*** *(NICOTINAMIDE ADENINE DINUCLEOTIDE)*	10mL	25mg/mL
☐ ***VITAMIN B6***	5mL	110mg/mL
☐ ***GAC*** *(GLUTAMINE 50MG, ARGININE 50MG, CARNITINE 100MG)*	10mL	
☐ ***LIPO V*** *(B1 10MG, B2 1MG, B3 10MG, B5 1MG, B6 1MG, B12 0.1MG, METHIONINE 25MG, INOSITOL 50MG, CHOLINE 50MG, L-CARNITINE 10MG, GLUTAMINE 1MG, VITAMIN C 5MG)*	5mL	
☐ ***MIC*** *(METHIONINE 25MG, INOSITOL 50MG, CHOLINE 50MG)*	5mL	
☐ ***MIC + B12*** *(METHIONINE 25MG, INOSITOL 50MG, CHOLINE 50MG, B12 1MG)*	5mL	
☐ ***MYERS COCKTAIL*** *(VITAMIN C 2000MG, MAGNESIUM 400MG, VITAMIN B1 100MG, B2 100MG, B3 100MG, B5 250MG, B6 100MG, B12 1MG)*	50mL	
☐ ***VITAMIN B COMPLEX*** *(B1 10MG, B2 1MG, B3 10MG, B5 1MG, B6 1MG)*	5mL	
☐ ***VITAMIN B COMPLEX + B12*** *(B1 10MG, B2 1MG, B3 10MG, B5 1MG, B6 1MG, B12 0.1MG)*	5mL	

☐ Yes, include syringes (extra fee applies)

Directions: _____Qty: _____ Refills:_____

Authorized Person: _____ Date: _____

Signature:_____

PRINT **CLEAR**