restore
HYPER WELLNESS + CRYOTHERAPY

Pregnancy/OB-GYN Medical Clearance Form

To: Restore Hyper Wellness	From: OBGYN Provider

Client Name: _____ Phone: _____Sex: _____
Age: _____ DOB: _____ Address:
_____

Your patient (listed above) is requesting a service offered by Restore Hyper Wellness. In the first trimester, Restore Customers are only provided fluids. After the first trimester of pregnancy, Restore Customers may be cleared to receive:

- One liter NS or LR weekly
- B-Complex (100/2/100/2/2 mg/mL) 1-2mL IV diluted in at least 100mL NS/LR fluids over 15 minutes once weekly
- Tralament (Trace Elements) 1mL Diluted in NS 100mL infused over 15 mins IVPB
- Ascorbic Acid 1000mg IVP over 3 minutes once weekly

As the OBGYN provider, you may also choose to provide clearance for other services. Please review and check the services your patient may receive based upon your assessment of their health history.

Provider, please check at least one of the below Restore services the client may receive.

- □ Ondansetron 4mg Please specify frequency and additional doses if necessary
  _____
- □ Additional IV Fluids - Lactated Ringers and Normal Saline Available
  - □ As needed up to 3 times a week
  - □ limited to Once a week
  - □ Other
    _____
    _____
- □ B6 50mg per dose, max of 100 per week – Has been shown to improve nausea in pregnancy.
- □ Other approved Ingredients or vital sign considerations - Restore's upper limit is 140/90, HR <100
  _____
  _____

Provider Response:

- ☐ No additional contraindications for IV Vitamin Micronutrient Therapy
- ☐ No special precautions for IV/IM Therapy

Provider Name: _____

Provider License State/Number (Must be licensed in state Restore services are administered):
_____

Provider Signature: _____Date:_____