Intravenous Therapy Referral for External Patients

CCNM Canadian College of Naturopathic Medicine | Integrative Cancer Centre

Dear referring naturopathic doctor:

Please complete this form and email it to **iccinfo@ccnm.edu** with supporting documents (the form should be completed with Acrobat Reader to most easily save the data). We will contact you if additional information is needed. If you wish to speak with our IV team, please email **iccinfo@ccnm.edu**. Once the referral has been approved, we will book the patient's first appointment and email you an update with the reassessment date. Patients should be reassessed by their referring ND prior to or after the completion of their recommended course of IVs to avoid delays or lapses in treatment. While the CCNM ICC clinicians will be fulfilling the duties of this referral, the referring ND is expected to provide ongoing patient care and management.

Patient's Name:_____ Date of Birth:_____

Today's Date:_____ Patient Contact:_____

DETAILED History of Present Illness (including concomitant health conditions):

_____
_____
_____
_____

A baseline physical exam must be completed (within one month) by either the referring ND or the CCNM IV provider:

Click here if you would like the IV provider to complete the physical exam: ☐
Vitals, date of exam:_____
Cardiovascular, date of exam:_____
Lung, date of exam:_____
Vascular, date of exam:_____
Abdominal, date of exam:_____

List any relevant, objective physical findings:

_____
_____
_____
_____

Recommended IV formula (check below, please indicate any modifications as well):

Vitamin C:
○ 25g ○ 50g ○ 75g ○ >75g
☐ Myers (○ with Glutathione [1g] or ○ without)
☐ Nutritional support (Myers' + amino acids)
☐ Cancer support (Myers' + amino acids + glutathione [1g])

☐ Immune support
☐ Glutathione [3g]
☐ HC

Modifications:

_____

Recommended frequency and duration of IV treatment (please be specific i.e., once a week for 8 weeks):

_____

_____

Does the patient require more than 15 grams of vitamin C per treatment?

- ○ YES (A G6PD test is required with this application)
- ○ NO

For your patient to have IV treatment, the following test results must be included with this application:

- ☐ Serum creatinine (within 6 months of this application OR 3 months if the patient has cancer)
- ☐ CBC (within 6 months of this application OR 3 months if the patient has cancer)

Do you have any additional reports/laboratory results that might be helpful?

- ○ YES (please include them with this application)
- ○ NO

Please list all current medications (including chemotherapy if applicable):

_____

_____

_____

Any allergies (i.e., foods, medications, etc)?

_____

_____

_____

Does the patient have a current/past history of infection with MRSA or any other communicable disease?

○ No ○ Yes, briefly explain here:_____

Are there any possible contraindications to IV therapy? If "YES", briefly explain here:

_____

_____

_____

Any additional notes:

_____

_____

Referring ND's name (printed):_____Referring ND's signature: _____

Contact Info: _____

IV supervisor signature:_____CCNM ICC Director signature:_____

*Upon acceptance, your patient will be notified and an appointment will be scheduled.

Instructions to clinic reception when booking patient:

☐ Please book for IV therapy

_____

_____