Parenteral Treatment Referral Form for External Patients

CCNM Canadian College of Naturopathic Medicine | Integrative Cancer Centre

Dear Referring Naturopathic Doctor:

Please complete this form and e-mail it to iccinfo@ccnm.edu with supporting documents. The form should be completed with Acrobat Reader to most easily save the data. The ICC Director or IV Shift Supervisor will contact you if additional information is needed. If you wish to consult with our IV team, please email Dr. Elise Hoffman at ehoffman@ccnm.edu, or call 416-498-1255 ext 257. Once the referral has been approved, RSNC Reception will book the appointment and we will send you an e-mail with the update and 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 care and management of the patient.

Patient's Name: _____ Date of Birth: _____

Today's Date: _____

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

Completed by the IV Supervisor: a physical exam within the PAST MONTH that includes:

- ☐ Cardiovascular date of exam: _____
- ☐ Lung date of exam: _____
- ☐ Peripheral Vascular date of exam: _____
- ☐ Abdominal date of exam: _____
- ☐ Vitals date of exam: _____

Please list any relevant objective physical findings:

Goals for parenteral protocol:

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

Vitamin C:

- ○ 25g ○ 50g ○ 75g ○ >75g
- ☐ Myers' Formula (○ with Glutathione ○ or without)
- ☐ Nutritional support (Myers' + amino acids)
- ☐ Cancer support (Myers' + amino acids + glutathione)
- ☐ Immune support
- ☐ Glutathione
- ☐ HCl

Recommended duration of parenteral treatment (please check and fill-in blanks below):

- ○ Once OR ○ twice every month for 1 months
- ○ Once OR ○ twice every week for 1 weeks
- ○ Once OR ○ twice every week for 1 months

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 a parenteral treatment, the following test result must be included with this application:

- ☐ A serum creatinine (within 1 month of this application date)

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

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

Please list all the patient's 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 parenteral therapy? If "YES", briefly explain here:

Any additional notes:

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

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

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