CCNM Canadian College of Naturopathic Medicine | Integrative Cancer Centre

Parenteral Treatment Referral Form for External Patients

Dear Referring Naturopathic Doctor:

Please complete this form and e-mail to iccinfo@ccnm.edu with supporting documents. The ICC Director or IV Shift Supervisor will contact you if additional information is needed.

IV treatment re-assessment is required and should be completed by you, the referring ND, after the approved IV treatment has been completed or after 6 months - whichever comes first. No further IV appointments can be booked before re-assessment has been completed. While the clinicians at the CCNM ICC will be fulfilling the duties of this referral, the referring Naturopathic Doctor is expected to provide ongoing care and management of the patient.

Once the referral has been approved, the RSNC Reception will book the appointment and inform the referring ND.

Patient's Name: _____ Date of Birth: _____

Patient's home/cell telephone # to book: _____

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

The patient must have had a physical exam within the PAST MONTH that includes the following:

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

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

☐ **No** ☐ **Yes, briefly explain here:**_____

Relevant objective physical findings:

Goals for Parenteral protocol:

Recommended Parenteral Protocol (check below, please indicate any modifications as well):

☐ Immune Support Formula

☐ Vitamin C ☐ 25g, ☐ 50g, ☐ 75g, ☐ >75g

☐ Myers' Formula

☐ Nutritional Support Formula/Cachexia Formula (Myers + Mixed Amino Acids)

☐ Glutathione

☐ Mistletoe subcutaneous injection

Recommended Duration of Parenteral Treatment (please check and fill-in blanks below):

- ☐ Once OR ☐ twice every month for ____ months.
- ☐ Once OR ☐ twice every week for ____ weeks.
- ☐ Once OR ☐ twice every week for ____ months.

Any possible contraindications to IV therapy based on your clinical evaluation of the patient?

- ☐ NO
- ☐ YES, briefly explain here: _____

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

- ☐ YES, then 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

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

Please list all the current medications (including chemotherapy if applicable) that your patient has been prescribed:

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

Today's Date: _____

Referring Doctor's Name (printed): _____ **Referring Doctor's signature:** _____

Practice location & contact: number: _____

IV Shift Supervisor: _____ **Director, CCNM ICC 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

Additional instructions to inform patients when booking:_____

_____

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