

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 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):

The patient must have had a physical exam completed by the intern within the PAST MONTH that includes:

- | | |
|--|---------------------|
| <input type="checkbox"/> Cardiovascular | date of exam: _____ |
| <input type="checkbox"/> Lung | date of exam: _____ |
| <input type="checkbox"/> Peripheral Vascular | date of exam: _____ |
| <input type="checkbox"/> Abdominal | date of exam: _____ |
| <input type="checkbox"/> 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:

- | | | | | |
|--|------------------------------|------------------------------|-------------------------------|---|
| <input type="checkbox"/> 25g | <input type="checkbox"/> 50g | <input type="checkbox"/> 75g | <input type="checkbox"/> >75g | <input type="checkbox"/> Immune support |
| <input type="checkbox"/> Myers' Formula (<input type="checkbox"/> with Glutathione <input type="checkbox"/> or without) | | | | <input type="checkbox"/> Glutathione |
| <input type="checkbox"/> Nutritional support (Myers' + amino acids) | | | | <input type="checkbox"/> HCl |
| <input type="checkbox"/> Cancer support (Myers' + amino acids + glutathione) | | | | |

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

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Once OR | <input type="checkbox"/> twice every month for _____ months |
| <input type="checkbox"/> Once OR | <input type="checkbox"/> twice every week for _____ weeks |
| <input type="checkbox"/> Once OR | <input type="checkbox"/> twice every week for _____ 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 shift supervisor: _____ CCNM ICC Director's 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
