Parenteral Treatment Referral Form

The Freeman Clinic

Dear Naturopathic Doctor,

Thanks very much for the referral to my clinic. I am happy to help! It is my priority to treat this patient as you would treat them in your own clinic and to ensure the best monitoring possible. It is also important that they achieve the health goals that you have set together. Over my years in practice, I have encountered many different scenarios of co-patient care. I would like to clarify by way of this form, how you wish to have this patient treated and monitored, and to ensure that we are both ensuring our licensing obligations. Please note that this is an intra-professional referral and it will be at the discretion of the naturopathic doctor performing the IV to approve of the treatment. While Dr. Allison Freeman ND will be fulfilling the duties of this referral, the referring doctor is expected to provide ongoing care and management of the patient. Once all of the treatment has been approved, the reception staff will book the patient.

Please check the following:

- ❏ If you are an ND who is not IV certified, I must do an intake with this patient to develop an appropriate IV treatment plan. Please provide the relevant details from your own case intake, to expedite this process for the patient. Fax to 416-761-9114
- ❏ If you are an IV who is currently IV certified, and you have created and implemented an IV treatment plan, I can accept a referral letter. This letter will suffice as a referral form with sufficient clear instructions, and faxed lab results. Fax to 416-761-9114

Please check the following as relevant:

- ❏ The patient wishes to do IVs at my location due to location convenience.
- ❏ The patient will remain under the primary naturopathic care of ND_____
- ❏ Monitoring of relevant labs going forward will be under the care of Dr. Freeman or referring to ND, or:
- ❏ Monitoring of relevant labs going forward will be under the care of the referring ND

Patient History Summary

Patient's Name:	
Patient'sl Phone Number:	
Patient's Age and Date of Birth (D:M:Y)	
Patient Home Address:	
Patient Email:	

Chief Concern and Goals for Patient	
Comorbidities and/or Relevant Objective findings	

Allergies	
Current Medications	
Supplements	
G6PD Status (Please Provide documentation)	❑ Normal G6PD: ❑ Abnormal G6PD ❑ Not yet tested
Treatment Requested	❑ Immune Formula ❑ Vitamin C (☐ up to 25 g ☐ up to 50 g ☐ up to 75 g) ❑ Myers' Cocktail ❑ Adrenal formula ❑ Glutathione ❑ Anti-nausea formula for Hyperemesis gravidum ❑ Intramuscular Vitamin D3 up to 50,000 IU ❑ Other: Please specify: **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

Does the patient have a current/past history of infection with MRSA or any other communicable disease?
☐No
☐Yes, briefly explain here:

Any possible contraindication to IV therapy based on your clinical evaluation of the patient?
☐NO
☐YES, briefly explain here:

Do you have any additional reports/laboratory results that might be helpful?
☐YES, please include them with this application
☐NO

Today's Date:

Referring Doctor's Name and License No.: _____

Referring Doctor's Signature: _____

Practice location/address: _____

Office telephone: _____ **Office Fax: _____**

The Freeman Clinic: Dr. Allison Freeman ND 1875, 804 Bloor St West Toronto ON M6G 1L9.
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