



Referral form for External Patients

Dear referring doctor:

Please complete this form and email it to info@painease.ca with supporting documents (We will contact you if additional information is needed). 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 practitioner prior to or after the completion of their recommended course of treatment to avoid delays or lapses in treatment. While the Pain Ease's clinicians will be fulfilling the duties of this referral, the referring practitioner is expected to provide ongoing patient care and management.

Patient Name

Report Date

Date of Birth

Patient Address

Phone (H)

Phone (W)

Email

City

Province

Postal Code

Referring Practitioner,

Please indicate your preferred method of communication by checking one of the boxes below:

Email

Fax

Phone

Service Required:

General Naturopathic Assessment and Labs

Intramuscular (IM) injection (Please Provide Details ,Recommended dose ,frequency and duration of the treatment (please be specific i.e., once a week for 4 weeks):

Vitamin B12

Vitamin D

Folic Acid

Intravenous (IVIT) Therapy (Please Provide Details ,IV formula ,osmolarity table,Recommended frequency and duration of IV treatment (please be specific i.e., once a week for 8 weeks):)

Vitamin C: 25g 50g 75g >75g

Myers (with Glutathione or without)

Nutritional support (Myers' + amino acids)

Cancer support (Myers' + amino acids + glutathione)

Immune support

Glutathione

Other (please specify)

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

YES (A G6PD test is required with this application)

NO

Acupuncture and Traditional Chinese Medicine

Naturopathic Cancer Care

Chief Complaint

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

PMHx:

Allergies :(Include medication, food, seasonal, pets, cosmetics, etc.)

Hospitalizations/surgery :

Medications: (Please list all prescription medications currently being taken)

supplements (Please list all supplements currently taken including vitamins and minerals, botanicals, homeopathics, amino-acids, etc.)

Any current/past history of infection with MRSA or any other communicable disease?

Relevant family history

Physical exam findings

Latest Blood work (CBC,ALT,eGFR...etc Please note a G6PD test is required for High Dose Vitamin C IV (more than 15 gm Vitamin C)

A baseline physical exam must be completed (within one month) by either the referring practitioner or an ND at Pain Ease Naturopathic Clinic.

Please 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 other relevant, objective physical findings:

Any additional notes:

We will contact the patient to set up an appointment date and time and then will confirm with the referring doctor date and time.

Referring Provider Signature:_____