PAINEASE
Naturopathic Clinic

**Parenteral Treatment Referral Form**
**for External Patients**

Dear Naturopathic Doctor:
This form must be filled out by you and approved by the Clinic Director and the IV shift supervisor ,Dr Abdullah Abd Elaziz,ND prior to booking and initiating parenteral treatments. 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 clinicians at the Pain Ease Naturopathic Clinic 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 Pain Ease Naturopathic Clinic reception staff will book the patient.

Patient's Name: Patient's Email :
Patient's home/cell telephone number to book: Patient's Age:
Patient's alternate phone number: Date of Birth:
Brief 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:
- ○ Relevant objective physical findings:

- ○ Family history of medical conditions :

- ○ Current Medical history :

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):
- ○ Immune Formula
- ○ Myers' Cocktail
- ○ Glutathione
- ○ Vitamin C ( up to 25 g up to 50 g up to 75g)

- ○ Freamine
- ○ Mistletoe subcutaneous or Intravenous 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:
Practice location/address:
Referring Doctor’s Name (printed): Referring Doctor’s signature:
Practice location/address:
Office telephone number: Home/cell telephone number:

Pain Ease Naturopathic Clinic In office use only :
Signature of the Clinic Director : _____
IV Shift Supervisor: _____
*Upon acceptance, your patient will be notified and an appointment will be scheduled. If applicable, all appropriate forms will need to be filled out by your
patient prior to he/she attends Pain Ease Naturopathic Clinic .

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