Intravenous Therapy Referral for External Patients

CCNM CLINICS | Integrative Cancer Clinic
Canadian College of Naturopathic Medicine

Dear Referring Doctor (ND or MD),

Please complete this form and e-mail it to **iccinfo@ccnm.edu** with supporting documents (the form should be completed with Acrobat Reader to most easily save the data). We will contact you if additional information is needed. If you wish to speak with one of our IV providers, please email iccinfo@ccnm.edu.

Once the referral has been approved, we will book the patient's first appointment and e-mail you an update with the reassessment date. Patients should be reassessed by their referring ND/MD before 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/MD is expected to provide ongoing patient care and management.

Patient's Name: _____ Date of Birth: _____

Patient contact information (address, phone number, email):

_____

_____

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

_____

_____

_____

_____

A baseline physical exam must be completed (within one month) by either the referring ND/MD or the CCNM IV provider. If you are unable to complete the physical exam, please indicate that you would like us to complete it: _____

Exam	Date	Relevant findings:
Vitals		
Cardiovascular		
Heart		
Lung		
Peripheral vascular		

Please list all current medications (including chemotherapy if applicable):

_____

_____

_____

Please list any known allergies (i.e., foods, medications, etc.)?

_____

_____

Does the patient have a current or past history of infection with MRSA or any other communicable disease? If yes, please briefly explain here:

_____

_____

Recommended IV formula (check below, please indicate any modifications as well):

Formula	Please check here	Frequency & Duration (e.g. weekly for 8 weeks)	Modifications
Vitamin C – 25g*			
Vitamin C – 50g*			
Vitamin C – 75g *			
Myers formula			
Myers formula with 1g glutathione			
Nutritional Support formula (Myers + mixed amino acids)			
Glutathione – 3g			

*Does the patient require more than 15 grams of vitamin C per treatment (note that our standard Myers formula contains 5g of IVC and nutritional support contains 10g IVC). If yes, a G6PD test is required with this application.

For your patient to have IV treatment, the following test results must be included with this application:

- Serum creatinine (within 6 months of this application OR 3 months if the patient has active cancer)
- CBC (within 6 months of this application OR 3 months if the patient has active cancer)

Are there any possible contraindications to IV therapy? If yes, briefly explain here:

_____
_____
_____

Any additional notes:

_____
_____
_____

Referring ND/MD name and signature: _____

Contact Info:

_____

IV supervisor signature:_____ CCNM ICC Director signature:_____

Instructions to clinic reception when booking patient:

☐ Please book for IV therapy

_____
_____