Naturopathic Oncology Referral Form

HealthSource
INTEGRATIVE MEDICAL CENTRE

Please FAX form and additional documents to 519-954-7951

PATIENT INFORMATION

Name _____ Birth Date _____ Age _____

Does the patient speak English? ___ Yes ___ No Other_____

Address _____ Gender *M* *F*

City _____ Province _____ Postal Code _____

Home Phone _____ Business/Mobile _____

Email _____

Emergency Contact Name _____ Phone _____ Relationship _____

PATIENT'S HEALTH CARE PROVIDERS

Medical Doctor_____ Location/Phone _____

Oncologist _____ Location/Phone _____

Specialists _____ Location/Phone _____

Other _____ Location/Phone _____

PATIENT'S DIAGNOSES

What is the patient's exact diagnosis (type of cancer and staging) along with any other diagnoses?

1) _____

2) _____

3) _____

Is this a primary (first time diagnosis) or recurrent cancer?

_____

Is the disease localized or spread (metastasized)?

_____

Is the patient currently receiving any conventional oncology treatments or do they have future treatments scheduled? (Please provide details and any side effects from treatment)

Chemotherapy (please specify which drugs): _____

_____

Radiation: _____

Surgery: _____

PATIENT NAME: _____

Has the patient received any conventional oncology treatments in the past? If so, please provide details.

_____

_____

Has the patient received any naturopathic or complimentary medical care? If so, please provide details.

_____

_____

REFERRAL INFORMATION

Date of referral _____ Referring Doctor _____

Office location _____

Phone number _____ Ext _____ Direct line _____

Email _____

Fax _____ Preferred method of communication _____

Service required:	☐ Complete Naturopathic Oncology ☐ Loco-Regional Hyperthermia (LRHT) ☐ Intravenous Infusion Therapy (IVIT)

SUPPORTING DOCUMENTATION Please send the following if available:

Reports	Faxed	Pending	Imaging	Faxed	Pending
Referral History and Physical			Chest X-Ray		
Operative Bronchoscopy			Other Plain Film		
Pathology Reports			Ultrasound		
X-Ray Reports			Bone Scan		
Chemo Schedule			CAT Scan		
Blood Work			Mammogram		
Pulmonary Function Tests			Receptors		
PET Scan			MRI		

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

Please note: Regardless of the referral type, patients will be required to have a paid consult with one of our Naturopathic Doctors prior to receiving treatment, as required by the College of Naturopaths of Ontario.

Referring Provider Signature _____