736 Arlington Park Pl., Kingston, ON K7M 8H9
T: 613.545.0454   E: ArlingtonParkHealth@gmail.com
F: 613.545.2493   W: NaturopathicDoctorKingston.com

IV Therapy Intake Form

Please bring this completed form to your first appointment. **The details you provide will remain confidential.**

Contact Details

Personal Information:

Name: ______________________ Date: ______________

Date of birth (dd/mm/yy): ______________ Age: ________ Gender: ________

Address: ______________________ City: ________ Postal Code: ________

Home Tel: ______________________ Work Tel: ______________

Email: ______________________________________

What is the best way for us to contact you? ______________________

May we leave messages at home or work? ______________________

Emergency Contact Information:

Name: ______________________________________

Relationship: ______________________ Tel: ______________

History

Healthcare Practioners:

Please list all other healthcare practitioners you are seeing:

1. ______________________ Tel: ______________
2. ______________________ Tel: ______________
3. ______________________ Tel: ______________

Health Concerns:

Please list your primary health concerns, in order of importance:

1. ______________________ Date of onset: ______________
2. ______________________ Date of onset: ______________
3. ______________________ Date of onset: ______________

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Please list all prescription and over the counter medications you are taking:

1. ______________________ Date started: __________ Dose: ____________
2. ______________________ Date started: __________ Dose: ____________
3. ______________________ Date started: __________ Dose: ____________
4. ______________________ Date started: __________ Dose: ____________

Please list all supplements you are taking (e.g. vitamins, herbal medicines, etc.):

1. ______________________ Date started: __________ Dose: ____________
2. ______________________ Date started: __________ Dose: ____________
3. ______________________ Date started: __________ Dose: ____________
4. ______________________ Date started: __________ Dose: ____________

Please list any allergies, sensitivities or adverse reactions (e.g. to medications, immunizations, foods, chemicals, scents, pets):

____

____

How much and how often do you consume the following?

Water: ______________________ Fruit juice: ______________________ Pop: _____________________

Caffeine: ____________________ Alcohol: ________________________ Tobacco: _________________

Desserts / sweets: _________________________ Recreational drugs: ____________________________

Do any of the following apply presently or in the past? (please indicate with a ✔)

Condition	Past	Present	Details
Liver disease			
Congestive heart failure			
Kidney disease			
Kidney stones			
Diabetes			

Is there anything else you would like to include on this form?_____________________________________

____

Thank-you.

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Consent for Collection, Use and Disclosure of Personal Health Information

Your health privacy is a primary concern. The personal health information you disclose to Dr. Gerann Murphy (N.D.) during your appointments will be handled in accordance with the *Personal Health Information Protection Act, 2004* and current privacy legislation and standards determined by the naturopathic regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status and health history.

Dr. Murphy and administrative staff of Arlington Park Health Professionals will collect, use and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Administrative staff of Arlington Park Health Professionals will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. They will collect, use and disclose your personal health information so as to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize Dr. Gerann Murphy (N.D.) and administrative staff of Arlington Park Health Professionals to collect, use and disclose my personal health information as outlined above.

Name ______________________ Date ______________________

Signature ______________________ Witness ______________________

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Consent and Authorization for Intravenous Therapy Treatment

As a patient, I have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as to whether or not to undergo intravenous therapy with Dr. Gerann Murphy (N.D.).

Intravenous therapy is the administration of vitamins, minerals, amino acids, anti-oxidants, herbal extracts, and other natural medicines directly into the bloodstream through placement of a catheter or needle into a vein.

Benefits of intravenous therapy include (but are not limited to): ensured absorption of medicine(s) at therapeutic doses much higher than can be achieved orally (resulting in desired clinical outcomes more quickly); the absorption of intravenous medicines are not affected by gastrointestinal disease (which often compromises absorption); and rapid repletion of nutritional deficiencies (resulting in improved immune function, enhanced energy, pain reduction, hastened recovery time from injury, potential anti-cancer effects, detoxification support, etc.).

Potential risks and side effects of intravenous therapy include: pain, bruising and infection at the site of injection; slight bleeding once the catheter or needle is removed; allergic reaction (including anaphylaxis) to an administered medicine (if this were to occur, immediate therapeutic interventions would follow to stop such a reaction); a warming or burning sensation at the site of injection and/or along the vein in which medicine(s) are being administered (due to the nature of certain medicine(s) – this is normal, but can be modified if uncomfortable); hemolytic anemia/shock in patients with G6PD deficiency; general malaise and fatigue post-treatment; and dizziness, feeling faint, or changes in blood pressure and blood sugar during or following treatment (again, due to the nature of certain medicine(s) – be sure to inform Dr. Murphy *[or who is responsible for your care that day*]* if any of these symptoms occur). Other rare, but possible risks and side effects include: fever, nausea, edema, upset stomach, difficulty breathing, arrhythmias, cardiac arrest, death and other unlikely and unforeseeable complications.

I agree to follow the guidelines below (as discussed beforehand by Dr. Murphy) prior to commencing intravenous therapy:

- Staying well-hydrated by drinking adequate water the day of treatment
- Informing Dr. Murphy of any allergies to any medicine (natural or otherwise), metal or other material
- Informing Dr. Murphy if you are pregnant, have kidney failure, liver or heart disease
- Informing Dr. Murphy of current or recent Methicillin Resitant (or similar) infectious disease
- Telling Dr. Murphy of any fears you may be having regarding treatment so that they can be addressed

I voluntarily consent to intravenous therapy treatment. I can request further explanation and information of the procedure. I understand that the medicine(s) administered in intravenous therapy could potentially produce some side effects in certain sensitive individuals, as well as interact with certain medications or lab tests (to be discussed by Dr. Murphy). I wish to rely on Dr. Murphy to exercise judgment in recommending the intravenous medicine(s) that she feels is in my best interest based on facts known at the time of treatment.

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I understand that if I have been referred to Dr. Murphy for intravenous therapy by another doctor (naturopathic or medical), Dr. Murphy is not my naturopathic doctor or primary care provider. I will continue my healthcare with my primary doctor (naturopathic or medical). I also understand that if my primary doctor (naturopathic of medical) devises an intravenous formula for Dr. Murphy to administer to me (provided they are qualified to do so), and I have a reaction (from mild to severe) to this administered formula that could have been prevented based on my primary doctor's (naturopathic or medical) knowledge of my health status, I absolve Dr. Murphy from any wrongdoing.

Your first intravenous therapy assessment appointment with Dr. Murphy will last 45 minutes and may include a physical exam and referral for laboratory tests. Follow-up consultation appointments may range from 15-60 minutes each according to individual health requirements. The first intravenous therapy assessment appointment fee is $150 and does *not* include the cost of laboratory testing (as required). Follow-up consultation fees are prorated at $200 per hour. Depending on intravenous nutrients used, intravenous therapy treatments range in price from $140-200. The frequency of intravenous therapy treatments will be discussed during your first intravenous therapy assessment appointment. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do.

I understand that there have been no assurances or guarantees of successful treatment made to me. I understand that I am free to withdraw my consent and to discontinue participation in these treatments at any time. I understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment – without 24 hours notice, **I understand that I will incur and pay a fee equal to the wasted materials plus 50% of the procedural fee** involved in preparing the medicine(s) to be administered.

*Intravenous therapy (including compounding of substances for injection) is a controlled act that can be delegated by Dr. Murphy to a qualified individual. As such, and with your consent, a Medical Laboratory Assistant/Technician extensively trained in intravenous therapy, will often be responsible for performing (and compounding substances for) intravenous therapy.

I HAVE READ AND UNDERSTAND THE ABOVE. Under the conditions indicated, I hereby place myself under the care of Dr. Murphy for intravenous therapy.

Signature (patient) Date

Please print name (patient)

Witness Date