



PYATT HEALTH CENTRE
NATUROPATHIC FAMILY MEDICINE & ONCOLOGY CARE

NATUROPATHIC ONCOLOGY & HYPERTHERMIA REFERRAL FORM

DATE OF REFERRAL ___ / ___ / ___ **REFERRING PRACTITIONER** _____
DD MMM YY ND MD OTHER

REASON FOR REFERRAL ___ Naturopathic Oncology ___ Hyperthermia

URGENCY ___ Urgent ___ Non-Urgent

PATIENT INFORMATION

Name _____ Date of Birth ___ / ___ / ___
DD MMM YY

Address _____
STREET NAME & # CITY, PROV POSTAL CODE

Phone # () - _____ Email address _____
HOME WORK CELL

CANCER DIAGNOSIS _____

___ Primary occurrence ___ Recurrence ___ Metastatic ___ Lymph node involvement

CHEMOTHERAPY ___ Past ___ Currently undergoing ___ Awaiting

Types of chemotherapy _____

RADIATION ___ Past ___ Currently undergoing ___ Awaiting

DIAGNOSTIC IMAGING ___ CT scan ___ PET scan ___ MRI

*Please include most recent imaging results

CURRENT NATUROPATHIC DOCTOR _____ **N/A** _____

CURRENT NATUROPATHIC TREATMENTS _____

OTHER PHARMACEUTICAL THERAPIES _____

Signature of Referring Practitioner _____ **Licence #** _____