

Dear New Patient:

Thank you for choosing Port Moody Health as your integrative health care provider. We are conveniently located in the scenic community of Port Moody. Free parking is available on the premises. Please note that our office is scent-free to respect those clients with allergies or sensitivities. The office accepts payment by debit, Visa, MasterCard, and direct billing. Most extended health care providers cover Naturopathic visits. Please check with your provider to determine the amount that is covered under your policy.

Enclosed are a contact form and a detailed cancer intake questionnaire.

Please ensure this is completed and submitted one (1) week prior to your appointment.

What to expect from your first visit:

- ✓ Please arrive **15 minutes prior** to your scheduled appointment to provide a urine sample prior to the start of your visit.
- ✓ The first visit with Dr. Sharon Gurm, ND, FABNO, is 75 minutes in length and involves a review of the detailed intake questionnaire, full health history, macroscopic urine analysis and, if necessary, may include a partial physical exam.
- ✓ Some laboratory tests, such as specific blood, urine or saliva analysis may also be recommended at this time **but are not included in the cost of the visit.**
- ✓ Subsequent visits vary from 15 minutes to 75 minutes in length.
- ✓ Treatments and therapies are an additional cost.

What we need before your first visit:

- ✓ Your completed new patient forms and Release of Records. Please fax or email these to us in advance so that we can upload your chart and request your medical records.
- ✓ Copies of any blood work or laboratory reports that are recent as of the last six months (or longer if appropriate) and any other pertinent documents.
- ✓ If possible, please bring medications or supplements that you are currently taking.

***INITIAL CONSULTATION FEE is charged at the time of booking and is NON-REFUNDABLE. In the event that you must reschedule your appointment we do require 2 business days' notice or the full charge of the visit fee will be applied. Changes can only be made in person or via telephone, not e-mail. Please note, all tests, product and treatment purchases are final. We do not issue returns or exchanges.**

While we deeply empathize with the unexpected difficulties that can arise, including the loss of a loved one, we want to inform you that our policy is non-refundable for initial consultations, and unfortunately, we are unable to provide a refund for the consultation fee in such circumstances. Thank you for your cooperation.

Kindly give us a call at 604-949-0077 if you have any questions.

We look forward to meeting you.

CONTACT INFORMATION

Full Name: _____ Preferred First Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Ethnicity: _____ Occupation: _____

Personal Health No. _____ BC Cancer Agency No. (if applicable): _____

Home Address: _____

City: _____ Postal Code: _____

Telephone: (home) _____ (work) _____ (mobile) _____

Preferred form of contact for reminder/follow-up calls: _____

Can we contact you via email? ☐ Yes ☐ No Initial: _____

Would you like to be informed about upcoming news and events? ☐ Yes ☐ No Initial: _____

Email: _____

Emergency Contact Name: _____

Relation: _____ Telephone: _____

Name of Medical Doctor: _____

Address: _____ Telephone: _____

Specialists: _____ Telephone: _____

Other Health Care Providers: _____

How did you hear of us? _____

Were you referred by someone? If yes, whom? _____

Cancer Intake Form

Please fill out this form to the best of your ability. It will help to assess your present state of health and assist in providing you with the best care possible.

Age: _____ Height: _____ Current Weight: _____

List all prescribed medications currently taken and include **dose, frequency, and duration** (how long you have been taking them). If you need more room, provide the information on a separate sheet.

- 1.
- 2.
- 3.

Allergies (medical, environmental, foods): _____

List all over-the-counter medications that you take (eg. Aspirin, Tums, Acetamephenol) and include **dose and frequency**:

Has any close relative (parent, grandparent, or sibling) had any of the following?

☐	Arthritis	☐	Allergies	☐	High blood pressure	☐	Skin Disease
☐	Asthma	☐	Endometriosis	☐	High Cholesterol	☐	Stroke
☐	Diabetes	☐	Gallstones	☐	Kidney Disease	☐	Tuberculosis
☐	Cancer Types:	☐	Heart Disease	☐	Osteoporosis	☐	Other

List any serious conditions, illnesses, surgeries and/or hospitalizations, along with the dates (including dental surgeries, tooth extractions, root canals, etc.):

List any severe accidents or injuries in the past along with the dates:

List all vitamins, minerals, herbal medicines, Asian medicines, or homeopathics you are currently taking and include dosage and frequency:

Do you use any of the following? List the type and frequency if applicable:

Alcohol: _____	Cigarettes: _____
Antacids: _____	Recreational Drugs: _____
Caffeine: _____	Tylenol/Aspirin/Advil: _____
Laxatives: _____	Other over-the-counter meds: _____

Are you currently pregnant? ☐ Yes ☐ No

Do you get regular screening tests done by another doctor? (PAP, blood tests, etc.) ☐ Yes ☐ No

Have you ever been screened for colon cancer (FIT test, colonoscopy) ☐ Yes ☐ No

List date(s), type of screening, and any findings/related procedures: _____

Have you ever been on hormone therapies? Indicate what and when if applicable: _____

Do you have any sexual difficulties or concerns around your sexual health? _____

Please list any known past or present toxic exposures (occupational, residential, medical, environmental, etc.):

Please list past regions of long-term residence (along with dates, duration) if different than your current residence: _____

Describe your general state of health as a child:

Describe your general state of health as a teenager: _____

How would you describe your general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any dietary restrictions, or food sensitivities or allergies? If so, please describe:



Please provide details about your average daily diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Water Intake: liters per day _____ Source: ☐ Tap ☐ Bottle ☐ Filtered ☐ Other: _____

Do you experience any gas, bloating, indigestion, or acid reflux? If yes, please describe:

How often do you have a bowel movement? _____

Do you exercise? If so, indicate the type, frequency and duration: _____

List your hobbies or interests: _____

Spiritual beliefs/religion: _____

How would you describe the emotional climate of your home? _____

How stressful is your work, or other aspects of your life? How do you manage stress?

How would you describe your present support network? How do you rate your level of support from 0-10? (0=no support, 10=excellent support network of friends and/or family)

Who are the members of your support network? _____

Do you have difficulty falling and/or staying asleep? If yes, please explain:

Do you wake up feeling refreshed? ☐ Yes ☐ No

Cancer Specific Information

Please indicate which conventional treatments you have had, are presently receiving, or plan to receive?

Chemotherapy: _____

Radiation therapy: _____

Surgery: _____

Other: _____

Are you currently engaged in any form of complementary cancer treatment? If so, please describe:

Please describe your short-term and long-term goals for coming to Port Moody Health:

On the chart below, please indicate which statement best defines your level of physical performance:

GRADE	ECOG PERFORMANCE STATUS*	CHECK ONE
0	Fully active, able to carry on all pre-disease performance without restriction	☐
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work	☐
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours	☐
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours	☐
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair	☐

*Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.

Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. *Am J Clin Oncol*. 1982;5:649-655.

Please assess the level of pain you may be experiencing and provide a rating between 1 & 10 (1 = no pain, 10 = extreme pain): _____

On the chart below, please indicate which statement best describes your overall Quality of Life (QOL).

GRADE	KARNOFSKY QOL SCALE	CHECK ONE
100	Normal, no complaints, no evidence of disease.	☐
90	Able to carry on normal activity; minor signs or symptoms of disease.	☐
80	Normal activity with effort; some signs or symptoms of disease.	☐
70	Cares for self; unable to carry on normal activity or to do active work.	☐
60	Requires occasional assistance, but is able to care for most of his personal needs.	☐
50	Requires considerable assistance and frequent medical care.	☐
40	Disabled; requires special care and assistance.	☐
30	Severely disabled; hospital admission is indicated although death not imminent.	☐
20	Very sick; hospital admission necessary; active supportive treatment necessary.	☐
10	Moribund; fatal process progressing rapidly.	☐
0	Unresponsive.	☐

Is there anything else that you feel may be important for us to know? _____

Thank you for answering all the questions. Complete answers to all the questions are to your benefit for the most effective naturopathic assessment, diagnosis and treatment.

This is a **confidential** record of your medical history and will be kept in this office.

The information contained here will not be released to any person except when you have authorized us to do so.

For research purposes, may we contact you for health updates? ☐ Yes ☐ No; Initial _____

May we use your information for research purposes? Your confidentiality will be strictly maintained.

☐ Yes ☐ No Initial _____

Acknowledgement and Informed Consent

Port Moody Health would like to take this opportunity to welcome you. This health clinic utilizes the principles of integrative medicine to aid in recovery from disease or illness, prevent disease or maintain overall health, and to improve quality of life by engaging the body's healing capacity. The naturopathic physician will conduct detailed case history; a physical exam as needed and may utilize standard and/or specialized tests as part of assessment and the diagnostic work-up. Treatment recommendations are made based on a comprehensive assessment and are individualized to address your specific health concerns. Some treatments or procedures may include vitamins, minerals, herbs, injections, IV therapy, nutritional and lifestyle counselling, and prescription medications, among others.

All female patients must alert the health care practitioners (mentioned above) if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

1. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or unless it is required by law. This privacy policy is in compliance with the CNPBC bylaws.
2. I understand that any advice given to me as a patient at Port Moody Health is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.
3. I understand that I am at liberty to seek, or to continue medical care with, another qualified health care provider.
4. I understand that as part of the comprehensive and team-oriented health care approach unique to this clinic, I may be seeing other clinic practitioners and information pertinent to my health and treatment outcome may be shared in order to facilitate the best health care provision possible.
5. I recognize the potential risk of some treatments that include but are not limited to: aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain, fainting or bruising from injection therapies or acupuncture, and inconvenience of lifestyle changes.
6. I understand that the Naturopathic Physician reserves the right to determine which cases fall outside their scope of practice, and that an appropriate referral will be recommended.
7. I understand that I am accepting or rejecting this care by my own free will and choice and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating.
8. I understand that no employee or physician at Port Moody Health is suggesting to me to refrain from seeking the advice of another health care provider.
9. I understand that the services offered here are not covered by MSP, and that fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests.
10. I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.

I understand that 2 full business days' notice is required for appointment cancellation or re-scheduling (via telephone or in person – not by email) or I will be responsible for the full cost of the missed appointment. X_____ Initials
*Please note that **ALL** testing and supplement purchases are final. We **DO NOT** accept returns or exchanges. Please check the box to verify you have read and understand our policy statement. X_____ Initials*

I, _____, have read, understood, and agree to the above statements.

Signature _____ Date: _____

Witness _____ Date: _____

Print parent/guardian's name _____

Signature of parent/guardian _____

PATIENT CODE OF CONDUCT

To provide a safe and healthy environment for staff, patients and their families, Port Moody Health expects patients and accompanying family members to refrain from unacceptable behavior that are disruptive or pose a threat to the rights or safety of others.

Patients and their families will:

- Treat staff & physicians with respect & honesty
- Refrain from making verbal threats to harm another individual
- Refrain from intentionally damaging equipment or property; throwing objects
- Refrain from making menacing gestures, physical assault, behaves violently in any real or perceived manner, inflict bodily harm
- Refrain from making harassing offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication, as well as in person interactions with physicians, employees or others.
- Refrain from discriminatory comments or actions regarding sexism, racism, ableism, classism, homophobia, biphobia, transphobia and any other behavior that is derogatory
- Supervise children in their care so that they are not climbing on furniture and respect other people's property
- Be prepared to work with other Port Moody Health staff when your usual Doctor, Nurse or Support staff is not available
- Understand that Port Moody Health works with many individuals with many levels of needs, and staff may need to prioritize their time to deal with emergency or high need situations.
- Maintain confidentiality of other patients and staff
- Understand that posting comments on social media that harass, bully or defame a doctor, clinic staff, or patients is unacceptable and could result in immediate dismissal from Clinic and services

Refusal of Service

Patients and their families have a responsibility to be respectful and considerate of others and the employees of Port Moody Health. The decision to refuse service is usually made by the employee in consultation with the Clinical Director when anyone has contravened any of the above and is disruptive to the clinic's ability to function. Violators are subject to removal from the clinic and/or discharge from the practice. Wherever possible, if a patient is refused service, that service user is provided with a referral to other appropriate agencies.

Print Name _____ Signature _____

Witness _____ Date _____

Print parent/guardian's name _____

Signature of parent/guardian _____

PATIENT RELEASE OF RECORDS

Physician: _____

Clinic Address: _____

Phone#: _____

Fax #: _____

Please accept this as a request for the following patient's clinical records/imaging results.

*** Please note that this is not a transfer of records request***

Specific Requests:

- ☒ All Specialist consults notes ☐ All recent blood work results
☐ All Imaging results ☐ Other

Imaging / Radiology Reports: ☐ Mammogram ☐ Ultrasound ☐ X-Ray ☐ MRI ☐ CT ☐ Bone

☐ PET scan ☐ Pathology / Biopsy Reports ☐ Other

☐ **URGENT** ☐ **Routine**

*** Please note that the patient will be responsible for any processing fees associated with reproducing medical records.***

Patient name: _____

PHN#: _____

DOB: _____

BCCA#: _____

Phone#: _____

Patient Signature: _____

Date: _____

Please Fax, Email or Mail Records To:

☐ **Dr. Sharon Gurm, ND, FABNO**

☐ **Dr. Paulina Domzal, ND**

Fax (604) 949-0017

E: info@portmoodyhealth.com

COLLABORATION | PRECISION MEDICINE | CLINICAL RESEARCH | INNOVATION

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Dr. Sharon Gurm, ND, Integrated Health LTD.

Cancer Care at PMH

Thank you for choosing us to be a part of your cancer care. To provide the most comprehensive care and maintain our highest standards, we kindly ask that you read and sign the following document. If you have any questions or concerns, please do not hesitate to ask one of our Care Coordinators for assistance.

By signing this document, I understand that I am required to comply with the following requirements if I choose to engage in IV therapies, LRHT (Local-Regional Hyperthermia) and/or PDT (photodynamic therapy) at Port Moody Health Integrative Medicine & Cancer Care:

Please Initial points 1-5

1. _____Scheduling follow up appointments as instructed by my physician. Bookings will be facilitated by the nurses and/or care coordinators. Further, I understand that the follow up visits are necessary for my prescribing physician to:
 - a. ensure safety and efficacy of the treatments.
 - b. adjust treatment orders and provide formal instructions to the nurses and residents administering treatment as required.
 - c. determine if blood or urine tests are required before proceeding with further treatments.
2. _____I understand that lack of compliance with the instructions provided by my prescribing physician can compromise my health and the expectations of treatment. As such, my prescribing physician at Port Moody Health Integrative Medicine & Cancer Care reserves the right to discontinue my treatment and services at the clinic at his/her discretion.
3. _____I understand that if I request a change to my treatment plan, a Care Coordinator will schedule a consultation with the prescribing physician to adjust the treatment order.
4. _____I understand that consultation fees are an additional billing item.
5. _____I understand that I can discontinue my treatment plan at any time.

I _____(print name) have read and agree with the above. I have been given a copy of this agreement for my own records.

Signature: _____

Date: _____

Full Name: _____

Witness Name and Signature: _____