



WELCOME TO INTEGRATIVE FORT LANGLEY

On behalf of the entire team, welcome to Integrative Naturopathic Medical Centre Fort Langley. This intake package is specific to your IV consultation and includes important personal health information, clinic policies, and consent forms required prior to treatment. Please ensure you read and complete the entire package carefully, as this information is required by your care team. We like to be upfront to avoid any possible confusion or inconvenience, and to ensure you have the best experience possible.

INCLUDED IN THESE FORMS

- Patient Intake Information
- Consents and Missed Appointment Policy

Our Location

23242 Mavis Avenue
Fort Langley, BC V1M 2R4

Office Hours

Mon-Fri 9:00am – 5:00pm
Sat 9:00am – 5:00pm

Running Late?

Please contact the front desk to inform us.

Contact Us

Phone: (778) 308-0101
Email: fortreception@integrative.ca

Cancellation Policy

2-business days
Monday through Friday

Phone Hours

Mon-Fri 9:00am – 4:30pm
Sat 9:00am – 4:30pm

Parking?

Parking in Fort Langley is limited and mostly street parking. To ensure you don't feel rushed, please plan to arrive 30 minutes early to allow time to find a spot.

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date: _____

Care Card Number: _____

PERSONAL INFORMATION

Full Name: _____		Preferred Name: _____	
Date of Birth: _____	Age: _____	Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other	Preferred Pronouns: _____
Home Address: _____		City/Province: _____	Postal Code: _____
Mobile Phone: _____	Home Phone: _____	Work Phone: _____	
Other Phone: _____	Email Address: _____		

Emergency Contact - Name: _____	Relationship: _____	Contact: _____
---------------------------------	---------------------	----------------

How Did You Hear About Us?

Google Search Google Ads Social Media Website Word of Mouth

Event/Workshop Newsletter / Email Referral (specify): _____

COMMUNICATION PREFERENCES

How would you like to receive reminders for your upcoming appointments (select one): Email Text

Email for reminders: _____ Phone for text reminders: _____

Would you like to receive emails that include newsletters, health tips, and upcoming events: Yes No

REASON FOR IV THERAPY

What is the primary reason you are requesting IV therapy today?

Hydration Fatigue Immune Support

Athletic Recovery Headache Nutrient Deficiency

Please briefly describe your symptoms or goals:

MEDICAL HISTORY

Please check all that apply: None

Heart disease High blood pressure Kidney disease

Liver disease Diabetes Asthma/COPD

Anemia Autoimmune condition History of fainting with needles

Other medical conditions (if any):

Current medications or supplements:

Allergies (medications, food, latex, etc): No Yes - Please list:

ADDITIONAL INFORMATION

Are you pregnant or possibly pregnant: No Yes N/A

Have you had IV therapy before: No Yes - Any reactions?

Consent to Use Email Communications

Risks of Email Communication

Email is a widely-used form of communication and can be convenient for patients to exchange information with a healthcare practitioner. However, using email to share medical information poses risks and the patient should be aware, understand and accept such risks including, but not limited to, the following:

- The privacy and security of email communication cannot be guaranteed
- Emails can be used to introduce viruses into computer systems
- Emails are easy to forge, easy to forward (sometimes accidentally) and may exist indefinitely

Conditions of Using Email

The healthcare practitioner/and or Integrative staff will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the healthcare practitioner/and or Integrative staff cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information. Therefore, the patient must consent to the use of email for patient information. Consent to the use of email includes agreement to the following conditions:

- Emails to and from the patient concerning diagnosis or treatment may be printed and placed into the patient's physical chart
- The healthcare practitioner may forward emails internally to the Integrative staff and to those involved, as necessary, for diagnosis, treatment, healthcare operations, and other handling
- The healthcare practitioner and/or Integrative staff is not responsible for information loss due to technical malfunctions
- The patient should not use email for emergencies or other time-sensitive matters
- The patient is responsible for updating email addresses and informing the healthcare practitioner and/or Integrative staff of any information that the patient does not want sent by email

Acknowledgement and Consent

Signature <small>(Patient, Parent, or Guardian)</small>	Date

Social Media Informed Consent

Integrative Naturopathic Medical Centre is pleased to participate in Social Media outlets such as Facebook and Instagram. Through these venues, we share staff and patient pictures, office updates, giveaways, and other fun and helpful information that may benefit our patients. With the expressed permission of our patients, we are pleased to share posts during an office visit, lab treatment, events, etc.

- I give my consent to allow Integrative Naturopathic Medical Centre to post photographs/videos of me on social media
- I do not give consent to my information/photographs/videos being shared on social media

Signature (Patient, Parent, or Guardian)	Date

Important Information

Missed Appointments and Cancellations

Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 2-business days notice, otherwise it may be necessary to charge for the time lost.

Fees

All visit charges are expected to be paid at the time service is rendered.

Extended Medical

Your medical insurance policy is a contract between you and your insurance company. This office does not collect payment from any insurance company nor guarantee reimbursement. We can provide receipts that can be submitted to your extended medical plan.

Informed Consent and Authorization for IV Therapy

Overview

Intravenous therapy is used at Integrative Naturopathic Medical Centre as a means to deliver nutrients and other medicines to your body by avoiding the digestive process. This is helpful in many cases where patients are depleted of certain nutrients, or when the substance can have more medicinal value intravenously.

As the patient, you have the right to be informed of the procedure, any feasible alternative options, and the risk and benefits. Procedures will not be performed until you have had the opportunity to receive such information and given your informed consent. Administration of IV therapies is provided by lab technicians with decades of experience.

Procedure

IV therapies involve inserting a sterile needle into your vein or muscle, and injecting a physician-prescribed formula. Alternatives to IV therapy include oral supplementation and/or dietary lifestyle changes.

Side Effects

- A relaxed or tired sensation from the IV
- A warm flushing sensation
- Light-headedness
- Short-term changes in the blood sugar levels
- Nausea or thirst

Risks

- Discomfort, bruising, and pain at the site of injection
- Inflammation of the vein used for injection, (phlebitis), infection
- Severe allergic reaction, anaphylaxis, cardiac arrest, and death

Benefits

- Injectables are not affected by stomach or intestinal disease
- The total amount of infusion is available to tissues
- Nutrients are forced into cells by means of high concentration gradient
- Higher doses of nutrients can be given than possible by mouth without intestinal irritation

Consent

You have the right to or refuse treatment at any time prior to its performance. Your signature affirms that you have given your consent for intravenous therapy as prescribed by your physician. The procedure will be performed under the direction of your physician by qualified and trained medical lab technicians.

Your signature below means that:

- You understand the information provided in this form and agree to the foregoing
- The procedure(s) set forth have been adequately explained to you by your physician
- You have received all the information and explanation you desire regarding the procedure
- You authorize and consent to the performance of intravenous therapies

Please Sign and Date

I have read and understand the above declaration. No guarantee of successful treatment has been implied. I understand that I am entitled to a copy of this consent form upon request and that I may withdraw this consent upon request in writing at any time.

Patient Signature <i>(Parent, Legal Guardian or Relative)</i>	Date