

Lemmo Integrated Cancer Care Inc.

330 – 2025 West 42nd Avenue

Vancouver, BC V6M 2B5

TEL (604) 788–8858

FAX (604) 263–6381

LEMMO
Integrated Cancer Care

www.lemmo.com

General Information

NAME	TODAY'S DATE (MM/DD/YY)
<hr/>	<hr/>
HEALTH CARE NUMBER	REFERRED BY
<hr/>	<hr/>
BIRTH DATE (MM/DD/YY)	AGE
<hr/>	<hr/>

Contact Details

STREET	CITY	POSTAL CODE
<hr/>	<hr/>	<hr/>
TELEPHONE (HOME/BUSINESS/MOBILE)		
<hr/>		
EMAIL ADDRESS		
<hr/>		
WOULD YOU LIKE TO RECEIVE DR. LEMMO'S ONLINE NEWSLETTER VIA EMAIL? (PLEASE CIRCLE)		YES NO
<hr/>		<hr/>

Emergency Contact

NAME	RELATIONSHIP TO YOU
<hr/>	<hr/>
TELEPHONE (HOME/BUSINESS/MOBILE)	
<hr/>	

Lifestyle

OCCUPATION(S)	YEAR(S)	HOURS PER WEEK		
<hr/>	<hr/>	<hr/>		
EDUCATION (LAST GRADE OR DEGREE COMPLETED)				
<hr/>				
STATUS (PLEASE CIRCLE)	SINGLE	MARRIED	COMMON LAW	OTHER
<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
SEXUALLY ACTIVE (PLEASE CIRCLE)	YES	NO		
<hr/>	<hr/>	<hr/>		
NUMBER OF CHILDREN	NUMBER OF SIBLINGS			
<hr/>	<hr/>			

Enrollment

REASON FOR VISIT
<hr/>
WHAT DO YOU EXPECT FROM THIS VISIT?
<hr/>
<hr/>

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ARE YOU WILLING TO MAKE LIFESTYLE AND DIET CHANGES? (PLEASE ELABORATE)

Medical History

SURGERIES (PLEASE INCLUDE APPENDIX, WISDOM TOOTH EXTRACTIONS, ETC.)

ACCIDENTS (MOTOR VEHICLE, TRAUMA, ETC.)

MEDICATIONS (LAST 24 MONTHS, INCLUDING ANTIHISTAMINES, ASPIRIN, TYLENOL, BCPS, ANTIBIOTICS, ZANTAC/TAGAMET)

SUPPLEMENTS (VITAMINS & MINERALS, HERBAL, HOMEOPATHICS, ETC.)

Family History

PLEASE SPECIFY TYPE AND RELATION OF FAMILY MEMBER TO YOU

CANCER

OBESITY

HEART DISEASE

ALCOHOLISM

DIABETES

MENTAL ILLNESS

ALLERGIES

DEPRESSION

STOMACH OR INTESTINAL COMPLAINTS

SEIZURES

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Medical Checkup History

FAMILY DOCTOR (NAME)

(PHONE NUMBER)

YOUR LAST GENERAL CHECKUP (MM/DD/YY)

DENTAL CHECKUP (MM/DD/YY)

EYE CHECKUP (MM/DD/YY)

HAVE YOU SEEN A NATUROPATHIC DOCTOR BEFORE? (PLEASE CIRCLE)

YES NO

IF YES, WHO?

Cancer History (if applicable)

ARE YOU UNDER THE CARE OF AN ONCOLOGIST? (PLEASE CIRCLE)

YES NO

HAVE YOU EVER RECEIVED TREATMENT FOR CANCER? (PLEASE CIRCLE)

YES NO

ARE YOU CURRENTLY RECEIVING TREATMENT? (I.E. CHEMOTHERAPY OR RADIATION) (PLEASE CIRCLE)

YES NO

IF NOT, WHEN WAS YOUR LAST TREATMENT? (MM/DD/YY)

Additional Medical Information

SERIOUS INFECTIONS (I.E. TB, MONO, PNEUMONIA, CHRONIC BRONCHITIS, ETC.)

ALLERGIES

HAVE YOU HAD LONG VISITS OR LIVED IN A FOREIGN COUNTRY? (PLEASE CIRCLE)

YES NO

IF YES, WHICH COUNTRY, AND HOW LONG AGO?

DO YOU USE... (PLEASE CIRCLE)

CIGARETTES?

COFFEE?

ALCOHOL?

RECREATIONAL DRUG(S)?

HOW DO YOU FEEL AFTER DRINKING COFFEE? (PLEASE CIRCLE)

NO EFFECT

RACING HEARTBEAT

HANDS SHAKE

LIGHT-HEADED FEELING

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Additional Medical Information (continued)

TIME YOU RETIRE (SLEEP)

TIME YOU WAKE-UP

DO YOU HAVE PROBLEMS... (PLEASE CIRCLE)

GETTING TO SLEEP? YES NO

STAYING ASLEEP? YES NO

DO YOU REMEMBER NIGHTLY DREAMS? (PLEASE CIRCLE)

YES NO

YOUR BLOOD TYPE

EXERCISE (HOURS PER WEEK) (PLEASE CIRCLE)

1

2

3

> 3 HOURS PER WEEK

WEIGHT: HAVE YOU EXPERIENCED CHANGES IN WEIGHT (INCREASE/DECREASE) DURING THE PAST 6 MONTHS?

(PLEASE CIRCLE) YES NO

IF YES, BY ABOUT HOW MUCH?

HOW IS YOUR APPETITE?

HAVE YOU EXPERIENCED ANY RECENT NAUSEA OR VOMITING?

YES NO

DO YOU SUFFER FROM PAIN? (PLEASE CIRCLE)

YES NO

IF YES, PLEASE BRIEFLY DESCRIBE

HAVE YOU HAD ANY FEVERS OF NIGHT SWEATS DURING THE PAST WEEK? (PLEASE CIRCLE)

YES NO

HOW DO YOUR BOWELS CURRENTLY WORK? (PLEASE CIRCLE)

REGULAR

DIARRHEA PRONE

CONSTIPATION PRONE

BOTH

OTHER (PLEASE SPECIFY)

DOES GOING TO THE BATHROOM INTERFERE WITH YOUR SLEEP? (PLEASE ELABORATE)

ARE YOU CURRENTLY TAKING ANY PAIN KILLERS (PLEASE ELABORATE)

HOW MUCH WATER DO YOU DRINK PER DAY? (PLEASE ELABORATE)

How would you generally rate the occurrence of colds and flus that you have received throughout the years? Please circle all that applies to you. If you have been diagnosed with cancer, please rate the occurrence before your diagnosis.

ALMOST NEVER

IT'S HARD FOR ME TO GET IT

THE TYPICAL 1-2 PER YEAR

LESS THAN 6 PER YEAR

MORE THAN 6 PER YEAR

ALWAYS SICK

OTHER (PLEASE EXPLAIN HERE)

How often do you receive the flu shot? Please circle all that applies to you.

NEVER

RARELY

OFTEN

ALMOST EVERY YEAR

(PLEASE ELABORATE)

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An important note about Dr. Lemmo’s oncology practice

Dr. Walter Lemmo is one of the few naturopathic physicians with an expertise and practice focused in cancer care in Canada. In light of this, members of the standard oncology community (*i.e.* medical/radiation oncologist, haematologist, pharmacist, oncology nurse, *etc.*) may regard Dr. Lemmo’s approach or recommendations as more experimental or controversial.

We have found throughout the years that these views largely depend on the person, their background, and what their school of thought may be. Part of Dr. Lemmo’s value to people diagnosed with cancer is his knowledge of the general issues and standard treatments in cancer care, combined with his expertise and clinical experiences in the area of naturopathic or integrated cancer care, to further help guide clinical judgments.

There are many conflicting opinions and bodies of information available in print and online to navigate through and it is not the intention to place a patient in the middle of any debate especially when going through cancer treatment(s). Ultimately, it is the patient’s choice to decide on which direction or approach they would like to incorporate into their cancer care program.

Dr. Lemmo advises that a patient trust their personal intuition and to follow a recommended path that possess the greatest comfort and the least amount of fear and stress in their cancer care journey whenever possible.

Please note that Dr. Lemmo is available to any healthcare professional or any part of a patient’s oncology team (*i.e.* oncologist, haematologist, nurse, pharmacist, GP, *etc.*) at any time, if there is an area of concern, question or harm. If such a situation arises, it is strongly urged that a telephone call be made to the office immediately and to please not use any email or letter sent by the mail system.

By signing the below, you have read and understand this letter.

PATIENT’S FULL NAME

SIGNATURE

DATE SIGNED (MM/DD/YY)

Updated November 2010

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Financial Policy

Updated July 2011

Dr. Walter Lemmo, ND is a licensed naturopathic physician registered with the College of Naturopathic Physicians of British Columbia. He provides his services through Lemmo Integrated Cancer Care Inc., a legal entity incorporated in the Province of British Columbia.

Consultations

First consultation (about 60 minutes):	\$ 225
Follow-up consultations (about 30 to 60 minutes):	\$ 150 per consultation
Phone consultation (about 60 minutes):	\$ 300 per consultation

Extended Health Plans

Extended health insurance, where applicable, may cover all or a portion for the fees. At the end of each visit, you will be given a sales receipt to submit to your extended health insurance carrier. Most extended health insurance plans offered by large corporations will have some coverage for naturopathic services. Please check with your particular carrier for its policies on coverage.

Other Costs

All **tests, treatments** and **remedies** are **not** covered by MSP (costs will vary). A **24-hour notice** is required for cancellations or you will be billed \$30.00 for each missed visit. **NSF Cheques** are charged at \$20.00 as a processing fee charged for each NSF cheque. The clinic reserves the right to change fees at any time. Please contact the clinic directly by phone or email to receive the latest information.

Research

There may be noteworthy findings, treatment results or outcomes that occur under the supervision of Dr. Lemmo, which could benefit future patients and the scientific research community if they are made aware. By being a patient of Dr. Lemmo, you are asked to provide consent for Dr. Lemmo to potentially use certain aspects of your medical data for scientific research and the potential publication of such research. **In any event, your personal information, such as your name, address, and telephone number, would be kept strictly confidential as part of standard medical research guidelines.**

By signing the bottom of this policy, you are indicating that you have read and understood the above statements and agree to pay upon receiving the products and services as outlined.

PATIENT'S FULL NAME

SIGNATURE

DATE SIGNED (MM/DD/YY)

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Dr. Walter Lemmo, ND

MSP Billing No. 30179

RECORDS RELEASE FORM

TO (PHYSICIAN OR MEDICAL CENTRE)

Could you please release the records of patient (print name) _____ to the above address or fax number of Dr. Lemmo.

Patient Information

FULL NAME

DATE OF BIRTH (MM/DD/YY)

PERSONAL HEALTH NUMBER (PHN)

Request

COMPLETE RECORDS	YES	NO	
RECENT RECORDS	YES	NO	DURING THE LAST (PLEASE CIRCLE) 1, 2, 3, 4, 5, 6 MONTHS
WBC/ICBC REPORTS	YES	NO	
X-RAY/ULTRASOUND	YES	NO	
MRI/CT-SCAN/PET-SCAN	YES	NO	
LABORATORY	YES	NO	
OTHER	YES	NO	PLEASE SPECIFY

Notes

PATIENT SIGNATURE

PHYSICIAN SIGNATURE

DATE SIGNED (MM/DD/YY)

DATE SIGNED (MM/DD/YY)