Dr. Deirdre Jasper BSc, ND (#074)
#5-414 Westmount Drive, Winnipeg, MB R2J 1P2
T: (204) 256-2273 F: (204) 257-2449 W: www.winnipegnaturopathicdoctor.ca

For your first ADULT (16+) patient consultation:

As requested, please find attached naturopathic intake materials and additional information. Please fill out and return all completed forms, including informed consent, to Dr. Jasper 2 BUSINESS DAYS PRIOR to your first appointment. PLEASE LET US KNOW IF YOU HAVE BLUE CROSS AS WE NOW PROVIDE DIRECT-BILLING FOR BLUE CROSS PATRONS.

Please list, in detail, any supplements and medications that you are currently taking, including name brands, name of supplement, dose, and how long you have been taking it. If you are taking a lot of supplements, you may wish to bring the bottles along to your appointment.

Please indicate any special diets that you are currently adhering to. Refer to the Diet Diary to log your diet for 3-days (at any time shortly before your initial the appointment).

I am also attaching the ***"Authorization for Release of Medical Information"*** form -- this form is optional to you and may be filled out and sent back to me ASAP, at which time I can FAX to your doctor(s). The purpose of this form is to release recent test results from your doctor(s) to your naturopathic file -- I use this information to help reach a diagnosis, and in order to better understand your health concerns. This is only done if I have your consent, and is not mandatory, but strongly encouraged.

If you have any other pertinent health information on hand please feel free to forward along as well.

You have the option of a 1.5-hr or 1-hr initial adult consultation. Be aware that part of an initial consultation (60- or 90-min.) may include a complaint-oriented physical exam. Please note, at this time I do not perform gynecological or prostate exams but can refer you to another practitioner that does.

At the first visit you may be given a wellness plan (diet, lifestyle and/or supplemental recommendations) and/ or referred for further testing. Please note, I do not collect blood samples on-site.

Payment is requested at the conclusion of the visit (we take cash, debit, e-transfer, Visa and Mastercard), and you may wish to keep the receipt to forward to your extended benefits health insurance company for reimbursement of naturopathic services. Please check with your insurance to find out what your coverage includes.

PLEASE NOTE that initial consultations and follow-ups may be conducted in person or virtually. Follow-up appointments may be provided via phone, video or in person for your convenience. Please read and sign the "***Consent and Waiver of Liability: Electronic Communication***" form if you wish to communicate by email with Dr. Jasper.

Thanks for your interest in naturopathic medicine and I look forward to meeting with you!

--Dr. Jasper

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Adult Patient In-take Form   Date filled out:

Surname: ____________ Given Names: ____________ Pronouns: ________

Birth date (dd/mm/yyyy): ____________ Complete Address: ____________

____________ E-mail: ____________

Home phone no.: ____________ Cell phone no.: ____________

Phone # to leave messages at?: ____________ Occupation(s): ____________

Marital status: ________ Children/ dependants: ____________

Emergency Contact (Name & Phone): ____________

Blue Cross certificate #: ____________ Blue Cross client #: ____________

Policy holder's name: ____________ Policy holder's DOB: ____________

NOTE: I only direct bill to Blue Cross. If you have a different provider you will need to submit receipts yourself.

How did you hear about us? ____________

Have you seen an ND before? (who, when?) ____________

Current health care providers (*please list name & occupation*):

____________ ____________ ____________

Main Health Concerns/ Diagnoses (date of diagnosis, if known):

____

____

____

Treatment goals:

____

Current Medications & Supplements (brand, dose, how long taken): ____________

____

____

____

____

Allergies/ Sensitivities? (*Foods, animals, environmental, etc.*) ____________

____

____

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Do you smoke tobacco? Have you ever? (When? How much per day? For how long?)

____

Diet Overview: Any diet restrictions (e.g. vegetarian, vegan, food allergies)? ________________

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Water ____

Beverages ____

How much of each do you consume per day (or week)?:

Soda pop		Coffee/Tea		Marijuana	
Candy		Alcohol		Recreational drugs	

Past Medical History (conditions, illness, injury): ________________________________

____

____

Hospitalizations/ surgery: ____

____

____

FAMILY HISTORY (***please state family member, i.e. mother, grandfather***, *etc.*):

Allergies		Arthritis	
Digestive problems		Osteoporosis	
Diabetes		Anxiety/ Depression	
High blood pressure		Cancer (what type?)	
Heart attack		Thyroid (low/ high)	
Stroke		Gynecological problems	
High cholesterol		OTHER?	

What are your stress management techniques (how do you “de-stress”)?

____

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Review of Systems – Please circle the best response & elaborate

Y A condition you have NOW and are currently suffering from
P A condition you had in the PAST or rarely/intermittently
N A condition you have NEVER had or almost never have

				Comments:
GENERAL				
Weight (lbs.) & height (in.)				
Are you /might you be pregnant?				
Fatigue (time of day? since when?)	**Y**	**P**	**N**	
SKIN				
Hives	**Y**	**P**	**N**	
Bulls-eye rash or a tick bite? (when?)	**Y**	**P**	**N**	
Eczema/ Dermatitis	**Y**	**P**	**N**	
Psoriasis	**Y**	**P**	**N**	
Acne / Boils / Cysts (explain)	**Y**	**P**	**N**	
Itching (where?)	**Y**	**P**	**N**	
Lumps (where?)	**Y**	**P**	**N**	
Dryness	**Y**	**P**	**N**	
Night sweats	**Y**	**P**	**N**	
Fingernail changes (what kind?)	**Y**	**P**	**N**	
Changes in moles	**Y**	**P**	**N**	
Skin cancer **/** Pre-cancer growth	**Y**	**P**	**N**	
Hair loss/ Unwanted hair growth (explain)	**Y**	**P**	**N**	
Dandruff	**Y**	**P**	**N**	
Fungal infections/rashes	**Y**	**P**	**N**	
Warts	**Y**	**P**	**N**	
HEAD				
Headache and/or Migraine	**Y**	**P**	**N**	
Head injury (concussion)	**Y**	**P**	**N**	
Dizziness / Vertigo / Lightheaded (circle)	**Y**	**P**	**N**	
EYES				
Impaired vision **/ Corrective lenses**	**Y**	**P**	**N**	
Eye pain	**Y**	**P**	**N**	
Tearing / Dryness (circle)	**Y**	**P**	**N**	
Double vision / Floaters (circle)	**Y**	**P**	**N**	
Glaucoma	**Y**	**P**	**N**	
Cataracts	**Y**	**P**	**N**	
Blurring	**Y**	**P**	**N**	
Bothered by sun	**Y**	**P**	**N**	
Itching	**Y**	**P**	**N**	
Redness	**Y**	**P**	**N**	
Discharge	**Y**	**P**	**N**	

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EARS				
Impaired hearing (Hearing aids?)	**Y**	**P**	**N**	
Ear pain	**Y**	**P**	**N**	
Tinnitus (ringing in ears; which side(s)?)	**Y**	**P**	**N**	
Itching	**Y**	**P**	**N**	
Discharge (Colour? Odour?)	**Y**	**P**	**N**	
Ear Infections (outer or inner canal?)	**Y**	**P**	**N**	
NOSE and SINUSES				
Stuffiness/ Congestion	**Y**	**P**	**N**	
Sinus pain	**Y**	**P**	**N**	
Runny nose (Colour?)	**Y**	**P**	**N**	
Post-nasal drip	**Y**	**P**	**N**	
Number of colds per year? (approx)				
Nose bleeds	**Y**	**P**	**N**	
MOUTH and THROAT				
Frequent sore throats / Strep throat?	**Y**	**P**	**N**	
Tonsils/ Adenoids removed (circle)	**Y**	**P**	**N**	
Sore tongue/ mouth	**Y**	**P**	**N**	
Gum problems (e.g. bleeding, receding)	**Y**	**P**	**N**	
Hoarseness	**Y**	**P**	**N**	
Mononucleosis (When diagnosed?)	**Y**	**P**	**N**	
Dental cavities (How many silver?)	**Y**	**P**	**N**	
Mercury fillings removed (When? #?)	**Y**	**P**	**N**	
Dentures/ partial (top / bottom)	**Y**	**P**	**N**	
Dental surgeries (what sort, when?)	**Y**	**P**	**N**	
Teeth grinding/clench (Night guard?)	**Y**	**P**	**N**	
Loss of taste	**Y**	**P**	**N**	
NECK				
Lumps	**Y**	**P**	**N**	
Swollen glands	**Y**	**P**	**N**	
Goitre (Enlarged thyroid gland)	**Y**	**P**	**N**	
Pain/ stiffness	**Y**	**P**	**N**	
RESPIRATORY				
Cough (dry, wet/ productive?)	**Y**	**P**	**N**	
Sputum / mucus	**Y**	**P**	**N**	
Spitting up blood	**Y**	**P**	**N**	
Wheezing	**Y**	**P**	**N**	
Asthma	**Y**	**P**	**N**	
Bronchitis	**Y**	**P**	**N**	
Pneumonia	**Y**	**P**	**N**	
Pleurisy (Inflammation of lung lining)	**Y**	**P**	**N**	
Emphysema / COPD	**Y**	**P**	**N**	
Difficulty breathing / shortness of breath	**Y**	**P**	**N**	
Pain on breathing	**Y**	**P**	**N**	

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Shortness of breath at night	Y	P	N	
Shortness of breath on lying down	Y	P	N	
Tuberculosis	Y	P	N	
Tuberculin Test (Test Result?)	Y	P	N	
Last chest x-ray (Date? Results?)	Y	P	N	
CARDIOVASCULAR				
Heart disease (heart surgery?)	Y	P	N	
Stroke or TIA (mini-stroke)	Y	P	N	
High / Low blood pressure (circle)	Y	P	N	
Heart murmurs	Y	P	N	
Rheumatic fever	Y	P	N	
Chest pain	Y	P	N	
Swelling in ankles	Y	P	N	
Palpitations, fluttering	Y	P	N	
Heart tests (explain)	Y	P	N	
BREASTS				
Lumps (eg fibrocystic breast disease)	Y	P	N	
Pain/ tenderness (eg PMS)	Y	P	N	
Nipple discharge (side, colour?)	Y	P	N	
Breastfeeding	Y	P	N	
GASTROINTESTINAL				
Difficulty swallowing (pills, food, fluids?)	Y	P	N	
Heartburn/ Indigestion	Y	P	N	
Change in thirst (Decreased? Increased?)	Y	P	N	
Change in appetite (Decreased? Increased?)	Y	P	N	
Any foods you CRAVE? (bread, sugar, carbs, salt, meat…)				
Nausea	Y	P	N	
Vomiting	Y	P	N	
Bowel movements per day?	Y	P	N	
Is this a recent change?				
Blood in stool / rectal bleeding	Y	P	N	
Frequent belching	Y	P	N	
Frequent passing gas (foul smelling?)	Y	P	N	
Jaundice (Yellow skin)	Y	P	N	
Liver disease (fatty liver, hepatitis, cirrhosis)	Y	P	N	
Gallbladder disease (gallstones, removal?)	Y	P	N	
Gastric ulcer or Gastritis?	Y	P	N	
Crohn's or Colitis (circle)	Y	P	N	
Irritable Bowel Syndrome (IBS-D, IBS-C...)	Y	P	N	
Food poisoning (when?)	Y	P	N	
Parasites / Pinworms (when?)	Y	P	N	
Diarrhea / Loose Stool (urgent?)	Y	P	N	
Constipation (hard, infrequent, incomplete)	Y	P	N	
Hemorrhoids / Anal Fissures (circle)	Y	P	N	
Black, tarry stool	Y	P	N	

Abdominal pain / Bloating	**Y**	**P**	**N**	
Hernia (belly button, groin, hiatus...)	**Y**	**P**	**N**	
URINARY				
Urination problems (describe)	**Y**	**P**	**N**	
Frequent urination (disruptive to you?)	**Y**	**P**	**N**	
Urination at night	**Y**	**P**	**N**	
Inability to hold urine (incontinence)	**Y**	**P**	**N**	
Bladder/kidney infections (how many?)	**Y**	**P**	**N**	
Kidney stones (passed?)	**Y**	**P**	**N**	
Blood in urine (microscopic or visible?)	**Y**	**P**	**N**	
Pelvic floor problems (describe)	**Y**	**P**	**N**	
REPRODUCTIVE – TESTES, PROSTATE, PENIS				
Testicular masses/ lumps	**Y**	**P**	**N**	
Testicular pain	**Y**	**P**	**N**	
Erectile dysfunction	**Y**	**P**	**N**	
Low libido / Sexual difficulties	**Y**	**P**	**N**	
Infertility/ difficulty conceiving?	**Y**	**P**	**N**	
Prostate enlargement/ infection/ cancer	**Y**	**P**	**N**	
Sexually transmitted infections? (describe)	**Y**	**P**	**N**	
Penis discharge/ sores	**Y**	**P**	**N**	
REPRODUCTIVE – OVARIES, UTERUS, VAGINA, VULVA				
Age of first period:				
Days of bleeding in cycle (How many days do you bleed each period?)				
Average cycle length (ie Day 1 = 1st day of period...how many days until the next period?)				
Bleeding/ spotting between periods	**Y**	**P**	**N**	
Irregular cycles	**Y**	**P**	**N**	
Painful menses (mild, moderate, severe?)	**Y**	**P**	**N**	
Excessive bleeding	**Y**	**P**	**N**	
Clotting (approx. size?)	**Y**	**P**	**N**	
PMS (Symptoms?)	**Y**	**P**	**N**	
Pain during intercourse	**Y**	**P**	**N**	
Low libido / Sexual difficulties	**Y**	**P**	**N**	
Sexually transmitted infections? (describe)	**Y**	**P**	**N**	
Birth control?	**Y**	**P**	**N**	
What type, and for how long?				
Number of pregnancies				
Number of miscarriages				
Uterine or ovarian diagnosis? (e.g. Uterine fibroids, endometriosis, PCOS…)				
Difficulty conceiving	**Y**	**P**	**N**	
Last menstrual period?				
Vaginal pain	**Y**	**P**	**N**	
Vaginal itching or irritation?	**Y**	**P**	**N**	
Abnormal vaginal discharge	**Y**	**P**	**N**	
Yeast infections (How many?)	**Y**	**P**	**N**	
Last PAP & pelvic (Date, Abnormal findings?)				

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MUSCULOSKELETAL				
Joint pain and/or stiffness (where?)	**Y**	**P**	**N**	
Arthritis (osteo- or rheumatoid?)	**Y**	**P**	**N**	
Broken bones (explain)	**Y**	**P**	**N**	
Muscle cramps/ spasms (frequency?)	**Y**	**P**	**N**	
Muscle weakness	**Y**	**P**	**N**	
Joint swelling	**Y**	**P**	**N**	
Lower / Upper back pain	**Y**	**P**	**N**	
PERIPHERAL VASCULAR				
Deep leg pain (location?)	**Y**	**P**	**N**	
Cold hands and/or feet	**Y**	**P**	**N**	
Varicose veins / spider veins (circle)	**Y**	**P**	**N**	
Hand and/or feet swelling	**Y**	**P**	**N**	
Raynaud's phenomenon?	**Y**	**P**	**N**	
Leg/ foot ulcers	**Y**	**P**	**N**	
NEUROLOGIC				
Fainting	**Y**	**P**	**N**	
Seizures/ convulsions	**Y**	**P**	**N**	
Paralysis	**Y**	**P**	**N**	
Numbness/ tingling (where?)	**Y**	**P**	**N**	
Loss of memory / Dementia	**Y**	**P**	**N**	
Twitching / Tics	**Y**	**P**	**N**	
Restless leg syndrome	**Y**	**P**	**N**	
Loss of balance	**Y**	**P**	**N**	
Speech problems (explain)	**Y**	**P**	**N**	
Neuro-behavioural diagnosis (e.g. ADHD)	**Y**	**P**	**N**	
Neuro-developmental diagnosis (e.g autism)	**Y**	**P**	**N**	
ENDOCRINE				
Heat intolerance	**Y**	**P**	**N**	
Cold intolerance	**Y**	**P**	**N**	
Known thyroid trouble? (describe)	**Y**	**P**	**N**	
Pituitary gland tumour?	**Y**	**P**	**N**	
Excessive hunger / thirst (circle)	**Y**	**P**	**N**	
Excessive sweating	**Y**	**P**	**N**	
Diabetes (Type 1 or Type 2?)	**Y**	**P**	**N**	
Low blood sugar (hypoglycemia)	**Y**	**P**	**N**	
Hormone replacement therapy (describe)	**Y**	**P**	**N**	
BLOOD				
Anemia / low iron (last checked?)	**Y**	**P**	**N**	
Low vitamin B12 (last checked?)	**Y**	**P**	**N**	
High cholesterol (last checked?)	**Y**	**P**	**N**	
Excessive bruising / bleeding (circle)	**Y**	**P**	**N**	
Other blood disorder? (describe)	**Y**	**P**	**N**	
Blood transfusion	**Y**	**P**	**N**	

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MEDICATION HISTORY				
Have you taken antibiotics for acne for 1 month or longer? (Name?)				
Have you, at any time in your life, taken other "broad-spectrum" antibiotics for respiratory, urinary, or other infections for 2 months or longer, or in short courses four or more times in a 1 year period?				
How many rounds of antibiotics you have taken in your lifetime? (approximately)				
Have you taken prednisone or other cortisone-type drugs? (when?)				
Have you taken heartburn medication? (name, how long?)				
Do you take aspirin, ibuprofen, naproxen or other NSAID medications? (how often?)				
ALLERGIC HISTORY & INFECTIONS				
Reaction to vaccine in the past? (Which one & explain?)				
Have you found black mould in your residence? (When?)				
Are you sensitive to scents, smoke or other airborne chemicals? (describe)				
Infection history (e.g. Strep, Mono, Lyme, Long COVID...)				
EMOTIONAL and LIFESTYLE				
Depression	**Y**	**P**	**N**	
Seasonal Affective Disorder	**Y**	**P**	**N**	
Mood swings (PMS or other?)	**Y**	**P**	**N**	
Anxiety or Nervousness	**Y**	**P**	**N**	
Schizophrenia	**Y**	**P**	**N**	
Bipolar disorder	**Y**	**P**	**N**	
Other mental health diagnosis:	**Y**	**P**	**N**	
Phobias (Please list)	**Y**	**P**	**N**	
Addictions (Please list)	**Y**	**P**	**N**	
Emotional traumas, PTSD? (describe)	**Y**	**P**	**N**	
Sleep problems (Insomnia, waking...)	**Y**	**P**	**N**	
Do you awake rested most of the time?	**Y**		**N**	
Hours of sleep per night? (Weekday)	**Y**		**N**	
Screen-time? (Hours per day)	**Y**		**N**	
Do you exercise? (What type, how often)	**Y**		**N**	
Do you have pets/ animals (Type?)	**Y**		**N**	
Have you ever been treated for drug dependence? (when?)	**Y**	**P**	**N**	

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3-DAY DIET DIARY

	Day 1:	**Day 2:**	**Day 3:**
Breakfast			
Lunch			
Dinner			
Snacks			
Water 1c. = 227ml			
# Bowel Movements			
Energy (1-10)			
Exercise			
Comments			

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Informed Consent to Naturopathic Treatment

Naturopathic Doctors are trained to evaluate their patients through interview, physical exams and through various laboratory tests. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Naturopathic Doctors are regulated by the Board of Directors, of the Manitoba Naturopathic Association, and under strict adherence to the Naturopathic Act. Every Naturopathic Doctor must maintain license/registration through their Association in order to legally practice.

Practitioners of Naturopathic Medicine may employ natural medicines and techniques such as nutritional counselling and nutritional supplements, botanical medicines, Asian medicines & acupuncture, homeopathic remedies, physical medicine (such as Bowen therapy), and lifestyle counselling.

Please check the following therapies listed below that you DO NOT wish to participate in, unless later indicated:

- ❑ ***Clinical nutrition*** is counselling on the application of healthy diet and/ or nutritional supplements to address nutritional deficiencies, treat disease processes, and promote overall health.
- ❑ ***Botanical medicine*** involves using plant-based medicines to assist in recovery from injury and disease and to promote general well-being. Herbs may be consumed or applied topically. Some examples include consuming herbs as teas, tinctures, tablets, capsules, creams, compresses, or suppositories.
- ❑ ***Homeopathy*** is a form of medicine using highly dilute quantities of naturally occurring plants, animals, minerals and other substances to stimulate the body's healing response. Homeopathy is effective at addressing the whole person, both on a physical and mental/emotional level.
- ❑ ***Acupuncture*** refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Moxabustion and cupping are additional Eastern soft tissue techniques that can be employed.
- ❑ ***Physical medicine*** refers to the use of hands-on techniques such as soft tissue manipulation (massage, acupressure), and the use of hot or cold applications to specific areas on the body to stimulate circulation (i.e. hydrotherapy).
- ❑ ***The Bowen Technique*** is a hands-on technique that involves the gentle manipulation of soft tissues at specific points on the body for the purposes of treating musculoskeletal, neurological and systemic conditions of the individual.
- ❑ ***Lifestyle counselling*** involves discussing and reforming daily habits (such as sleep hygiene, exercise regimes, and relaxation techniques), as well as removing risk factors to one's health.

During your initial consultation your Naturopathic Doctor will guide you through a case-taking interview, may perform a physical examination, request a urine sample, and/or recommend any necessary laboratory analyses. You may be referred to an external laboratory or health care practitioner for certain diagnostic testing (e.g. blood tests, saliva testing, imaging studies, etc.)

When necessary, it is the responsibility of the Naturopathic Doctor to refer to other healthcare practitioners for confirmation of diagnosis of an illness, disease, or any physical or mental disorder. Naturopathic Doctors are not trained to dispense pharmaceutical medications, perform surgery, order diagnostic imaging, or provide psychiatric counselling services.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or those taking multiple prescription medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your Naturopathic Doctor immediately.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks *(not an exhaustive list)*: aggravation of pre-existing symptoms, allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections or procedures, fainting or puncturing of an organ with acupuncture needles, or muscular/soft tissue pain from hands-on treatments.

Potential benefits (not an exhaustive list): restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of illness and disease, assistance in injury and disease recovery, and the prevention of disease and its progression.

Naturopathic Doctors are in no way accountable for the outcome of treatment(s) given in adherence to the Naturopathic Act; they in no way guarantee a "cure" of any illness or disease. Naturopathic Doctors shall provide empathetic, professional, and unbiased care for all patients that request treatment. The Naturopathic Doctor and the patient reserve the right to terminate Naturopathic care/ treatment at any time, as they deem necessary.

I understand that a record will be kept of the health services provided to me. As a patient, I shall provide my Naturopathic Doctor with updated information pertaining to my health to the best of my ability. Information will be gathered solely for the purposes of treatment, and will be kept confidential and shall not be released to other parties without my consent, unless required by law. I understand that I may request any portion of my medical record by paying the appropriate fee.

I understand that I may be charged a fee for medical questions via email communication.

I understand that all charges are to be paid at the time of the visit unless specific arrangements have been made prior to my scheduled appointment. I understand that a fee may be charged for any missed appointments or late cancellations (less than 24 hours). Exceptions will be considered in cases of a family or health emergency, or in cases of illness.

With this knowledge, I voluntarily consent to Naturopathic treatments offered or recommended to me by my Naturopathic Doctor, unless omitted as indicated above. I realize my Naturopathic Doctor has made no guarantees regarding cure or improvement of my condition, nor do I expect the Doctor to anticipate and explain all potential risks and complications. I intend this consent to apply to all my present and future Naturopathic care, unless a new agreement has been reached and a new consent form has been signed.

Dated this _____________day of ________________, 20______.

_____________________________	___________________________________
Patient's Signature	Guardian's Signature (under 18 years)
_____________________________	___________________________________
Patient's Name (please print)	Guardian's Name (please print)

Dr. Deirdre Jasper BSc, ND (#074)
#5-414 Westmount Drive, Winnipeg, MB R2J 1P2
T: (204) 256-2273 F: (204) 257-2449 W: www.winnipegnaturopathicdoctor.ca

Consent and Waiver of Liability: Electronic Communication

Electronic communication is a widely accepted form of communication. While it cannot replace personal encounters between you and your health care provider, it can be a convenient way to exchange information. All electronic communication will be acknowledged in a timely fashion. However, we do not monitor emails when the office is closed for weekends, evenings, statutory holidays and vacations. Please consider our office hours when you are waiting for a reply to your electronic communication. As a general rule, we will respond to patient emails within 3 business days. If you do not receive a response within the designated time period, please assume that your email was not received and call the office to follow up.

I understand and agree that:

- Electronic communication is not an appropriate substitute for clinical examinations. I am responsible for following up on Dr. Deirdre Jasper N.D.'s (Dr. Jasper ND) electronic communication and for scheduling appointments where warranted;
- Electronic communication is not to be used in emergencies, or when I need information or advice urgently. In case of an emergency, go to your nearest urgent care facility or call 911;
- Electronic communication will not be used for any purpose outside the context of my direct patient-health care provider relationship;
- Electronic communication between me and Dr. Jasper ND will become part of my confidential patient record;
- This medical practice may use electronic communication to send me health promotion material and other educational resources;
- Electronic communication is a privilege that may be withdrawn at the discretion of Dr. Jasper ND;
- Electronic communication between Dr. Jasper ND is only for the residents of Manitoba and is governed by the laws of the Province of Manitoba;
- Electronic communication is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the electronic communication once it has been sent;
- Electronic communication can introduce viruses into a computer system and potentially damage or disrupt the computer;
- Electronic communication can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the physician or patient. Electronic communication senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients. Electronic communication is indelible. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or cyberspace;
- Use of electronic communication to discuss sensitive information can increase the risk of such information being disclosed to third parties;
- Emails may be forwarded or referred, as necessary, for diagnosis, treatment, or health care operations, with the permission of the patient;
- Dr. Deirdre Jasper N.D. is not responsible for information loss due to technical failures;
- I will notify the Dr. Jasper ND of any changes to my electronic communication address;
- I acknowledge Dr. Jasper ND's right to, upon provision of written or electronic communication notice, withdraw the option of communicating through email;

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I hereby authorize Dr. Deirdre Jasper, N.D. to disclose my personal health information to me via the following:

Email address (print clearly): ____

Mobile number to be used for texting (if applicable): ____

I have read and understood the "**Consent and Waiver of Liability: Electronic Communication"** form and fully acknowledge that sending personal health information via electronic communication is not secure and I fully accept the risks and responsibility involved with this. I hereby waive any and all claims against Dr. Deirdre Jasper N.D. in connection with the disclosure of my personal health information via email.

Name of Patient (print): ____

Signature of patient (or guardian/ legal representative): ______________________________ Date: ___________

Relationship to patient (if signed by guardian/ representative): ____

Dr. Deirdre A.W. Jasper BSc, ND (#074)
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PLEASE NOTE THAT THIS DOCUMENT DOES NOT INDICATE A TRANSFER OF PATIENT CARE!

Authorization for Release of Medical Information

Patient's Name: ______________________________ Date of Birth: ______________
Address: ______________________________ City: ______________________
Prov/ State: ______________ Postal Code/ Zip: ________________

MH Reg # (6-digit): ______________________ **PHIN (9-digit):** __________________________

(Practitioner's info here:)

- ❑ I authorize Dr. Jasper to ***OBTAIN*** information from:

____
Name of Provider or Facility

____
Address

____
City, Prov/ State, Postal Code/ Zip

____
HCP's Fax # (include area code) / Tel #

TYPE OF RECORDS REQUESTED (typically, past 1-2 years, especially blood work):

____
____

Signature of Patient (or Representative): **X**______________________________________

Relationship of Representative to Patient: ______________________________________

Date: ______________________

PLEASE NOTE THAT THIS DOCUMENT DOES NOT INDICATE A TRANSFER OF PATIENT CARE!