# Naturopathic and Allergy Clinic2021

**Telephone (416) 207-0207, fax (416) 207-0272**

**Email:clinic@live.com**

## Confidential Preceptorship Form (to be completed before your visit in INK only please)

**Version january 2021**

**Dear Preceptor:** This form was specifically prepared by our naturopathic doctor**,** the clinic director Fateh Srajeldin BSc., ND, to help you express your interests from this preceptorship session. We also wish understand your field of interests and your goal from choosing to preceptor at this clinic. Please tell us in few words about your field of interest and future specialization. Depending on availability at our office , you may earn preceptor hours by following a naturopath, a chiropractor, an RMT, an osteopath, an acupuncturist, a homeopath, a colon therapist and an IVIT ND. Dr. Srajeldin will facilitate available hours with other professionals at the office, given that patients consent to your attendance during treatment session and time availability. The information on this sheet is confidential. **Thank you.**

**Student's confidential information**

Last name: _____ First name: _____.

Have you practiced as an MD, DC, RMT or Pharmacist, Yes ❒, NO ❒, explain please :_____.

Cellular number ( ): _____ email: _____ @ _____.

Attending college : _____. Current year of study :_____>

Date you are available for preceptorship: _____. from:_____. to:_____.

I would like to have my Lunch at: _____. to: _____.

Today, I would like to preceptor in the following fields:_____.

In case of an emergency who may we contact

First name: _____ Last name: _____ Relationship: _____.

Telephone (H): ( ) _____ (W): ( ) _____ Ext. ____ Cellular: ( ) _____.

Dear preceptor:

Welcome to the Naturopathic Wellness and Allergy Clinic in Toronto, a clinic that served the community over thirty years at one location. We thank you for choosing this clinic for some of your preceptorship hours.

We wish to bring to your attention the following points.

- Bring your own white coat.
- Wear your CCNM name tag.
- You must shut off your cell phone completely, (not on vibrate), during your attendance of a patient's session.
- Once the session starts, there is no in-out privileges.
- You acknowledge and consent that all information is confidential and you are not at any liberty to discuss them outside our clinic.
- You acknowledge and consent that no recordings or photography are not permitted of any patient.
- You acknowledge and consent that you are not at liberty to convey diagnosis, treatments, therapies or clinics to the patients.
- You acknowledge and consent not to discuss politics, religion or sexuality with patients.
- You acknowledge and consent to wear unrevealing garment such as short skirts or open tops.
- You acknowledge and consent not to exchange personal or professional information with patients.

## Mandatory by law that COVID questionnaire for everyone and every visit

Naturopathic Doctors and all other regulated health practitioners are required by the Ontario Ministry of Health & Long-Term Care to screen every patient attending an in-person appointment. If you answer "yes" to any of the following questions, we cannot see you for an in-person appointment and you must get tested for COVID-19.

- **Do you have now or recently developed any of the following symptoms?**
  - Fever ❒ Yes ❒ No
  - New onset of cough ❒ Yes ❒ No
  - Worsening chronic cough ❒ Yes ❒ No
  - Shortness of breath ❒ Yes ❒ No
  - Difficulty breathing ❒ Yes ❒ No
  - Sore throat ❒ Yes ❒ No
  - Difficulty swallowing ❒ Yes ❒ No
  - Decrease or loss of sense of taste or smell ❒ Yes ❒ No
  - Chills ❒ Yes ❒ No
  - Headaches ❒ Yes ❒ No
  - Unexplained fatigue/muscle aches ❒ Yes ❒ No
  - Nausea/vomiting diarrhea, abdominal pain ❒ Yes ❒ No
  - Pink eye (conjunctivitis) ❒ Yes ❒ No
  - Runny nose or nasal congestion ❒ Yes ❒ No
  - Have you travelled outside Canada in the last 14 days? ❒ Yes ❒ No
  - Have you tested positive for COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE? ❒ Yes ❒ No

Signature of Patient or Guardian (MUS

Date: _____. Signature: _____.