KAYLA ADEBAJO, NP-PHC

Urban Integrative IV and Detox Clinic
615 Yonge Street, 6th Floor
Toronto, Ontario, M4Y 1Z5
Telephone (416)463-2911 • Fax 1(888) 676-2476

Personal Demographics

Name	Date of birth	Health Card #
Address	City State	Postal Code
Home phone	Work phone/Cell phone	Other Contact #
Email	Marital Status Married Single Other:	
Emergency Contact	Phone	
Employer	Position	Full-time Part-time Other:

Primary Care Physician

Name	Phone/Fax Number	
Address	City	Postal Code
Pharmacy information:		Fax #:

Presenting Symptoms

Vital Signs: BP________T______P______R_____

Wt.__________Ht.______________BMI __________

Are you satisfied with your weight and shape? **Yes** **No** Your ideal weight is___________

Compared to an ideal weight, your current weight is:

More than 10lbs below Within 10lbs + or - 11-20lbs over 21-40lbs over 41+ lbs over

How would you describe your body shape? (please circle)

Weight is evenly distributed Pear-Shaped (heavier in hips/lower body) Apple-shaped (heavy in stomach/upper body)

Please briefly describe your current symptoms of concern and why you are seeking treatment?
Of the above, what are your top 3 concerns that you would like to have addressed within a 3-6 month timeframe?

What therapies/procedures are you interested in or already are in involved in?
(Please check all that apply)

Bio-Identical Hormone Therapy: • Natural Thyroid Hormone Replacement • Testosterone Replacement Therapy • Human Growth Hormone • Adrenal Fatigue Treatment	
Functional Medicine: • Ozone and oxidative therapies • IV Nutrition Therapy (e.g. Meyer's, Glutathione) • High Dose Vitamin C • IV Heavy Metal Chelation • IV Cardiovascular Chelation • Chronic Inflammation treatment for biotoxins/mold/Lyme Disease	
Integrative Therapies: • Holistic Nutrition Support (Ketogenic Diet/Intermittent Fasting, Low Inflammation Diets) • Nutritional Supplements • Sublingual and/or injection allergy desensitization immunotherapy treatments	
Psychotherapy: • Hypnosis • Neurolinguistic Programming	
Sexual dysfunction treatment with Platelet Rich Plasma (PRP): • O-Shot for Women • P-Shot for Men (Erectile Dysfunction)	
Aesthetics: • PRP for thinning hair and hair restoration • Face PRP/Vampire Facelift • Botox/Neuromodulators • Dermal Fillers • Hyperhidrosis (underarm sweating)	
Medically Supervised Weight loss (HCG DIET/ Dr. Simeon Protocol)	

Patient Name:______________________________ **DOB:**__________ **Date:**________

Past Medical History	
Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.	
Date	**Medical diagnosis, illness, accident**

Past Surgical History	
Date	**Surgery**

Specialists/Other Health Care Providers			
Please list any current or previous specialists or health care providers you have consulted with in the past five years. E.G. Dermatologist, Allergist, Gastroenterologist, Cardiologists, Psychologists, Physiotherapy			
SPECIALIST NAME	SPECIALTY	PURPOSE	CONTACT INFO (Location/#)

Patient Name:_____________________________ **DOB:**__________ **Date:**________

Medications: Please list ALL prescription medications. Include **ALL** over the counter medications, **supplements, and vitamins** that were used within one year if discontinued.

Name of Medication/Supplement	Dosage	Purpose/Dosing schedule

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Do you have a preferred route in which you would like to take your prescribed hormone therapy?
(Please note that certain routes may not be available—your practitioner will counsel you on best routes based on your medical history)

☐ By mouth (under tonque, capsules or tablets) ☐ Through the skin in creams or patches
☐ Intramuscular injections or subcutaneous ☐ No preference ☐ Other____________

Allergies

Are you allergic to any MEDICATIONS (Prescription or OTC), Environmental? List All

Patient Name:______________________________ DOB:__________ Date:________

Family History

Please list ALL known family illness:
(e.g. heart disease, stroke, diabetes, blood clot history,hypertension)
Cancer history (e.g. breast, cervical, skin, prostate, lung, blood), etc.
If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/ Cause of Death
Mother		
Father		
Brothers		
Sisters		
Spouse		
Children		

Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? ____________
- How many total years have you smoked? ____________

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? ☐ None to 2 ☐ 3-7 ☐ 8-14 ☐ 15 or more drinks/week
  Types of alcohol____

Do you now or have you in the past used any recreational drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? ☐ Yes ☐ No

- If yes, what substance(s) and how often? ____
  ____

Do you drink coffee/caffeinated beverages? If yes how many cups (8oz/250ml) do you drink in a day?
☐ 1-2 cups ☐ 3-4 cups ☐ 4-5 cups ☐ I usually drink a whole pot or more to stay awake!

Patient Name:_____________________________ **DOB:**__________ **Date:**________

Social History

Exercise/Activity Level

Do you participate in regular physical activity or exercise? ☐ Yes ☐ No

On average, how many days per week do you exercise?_________How many minutes per day? __________

What activities do you engage in? (Please list all e.g. high interval training, aerobics, dance, walking, cross-fit)

____

Do you have activities or hobbies you wish to engage in, but have not as yet? Please tell us more:

____

Stress Experiences

(Please answer below-this will help to get a better understanding of how stress is affecting your adrenals)

In the past 12 months how often have you felt excessive stress in your life?

☐Never ☐Occasionally ☐ Often ☐ Almost Always

Have you had any recent life stressors in the past three years?

Please list or describe any recent life stressors in the past 1-3 years (divorce/marriage, change of address, difficult boss, new job):____

____

Do you have any history of traumatic events, violence, conflict, or living in an abusive environment?

If yes, when did these occur? (Please check all that apply).

☐Early childhood (age 0-12 years) ☐ Teenage/young adult (age 13-24 years) ☐ Adult (age25-44 years)

☐ Midlife (age 45-64 years) ☐ Older Adult (65+ years old)

Nutrition Practices

How many vegetable servings do you consume daily on average? (This does not include fruit servings)

☐Hardly ever—I do not like veggies ☐1-2 servings ☐ 3-4 servings ☐ 4-8 servings ☐ 8+ servings

How many servings of water do you drink daily on average? (A serving is a cup/250ml or 8ozs)

☐Hardly ever—I do not like water ☐1-2 servings ☐ 3-4 servings ☐ 4-8 servings ☐ 8+ servings

In general, would you say your healthy nutritional intake is:

☐Excellent ☐Very Good ☐ Good ☐ Fair ☐Poor

Sleep Practices (Please answer if sleep is an issue you would like addressed)

I would rate my sleep quality as:

☐Excellent ☐Very Good ☐ Good ☐ Fair ☐Poor

How many hours of sleep on average do you get each night?

☐Less than 4 hours ☐4-6 hours ☐ 6-8 hours ☐ 8+ hours

On average, how long does it take to fall asleep?

☐I fall asleep right away ☐15-30 mins ☐ I lie awake for a long time, more than 1 hour

Patient Name:______________________________ **DOB:**__________ **Date:**________

Social History

Sleep Practices continued

Do you experience night time awakenings? If yes, how many times on average do you wake up at night? *(Including having to get up to use the washroom)*
☐I sleep soundly all night ☐I toss and turn ☐ I'm up 1-2 times ☐ I'm up 2-3 times ☐ I'm up 3+ times

In the morning when you wake up, you feel…

☐Invigorated and ready to go ☐Most times feel refreshed
☐ Frustrated that your sleep is cut short, but your are able to get up and get going
☐ Like you haven't slept at all

Do you experience low energy/fatigue during the day? *(e.g. where you will need to get another coffee to function?)* Please describe when this typically occurs, what are your symptoms, and what you normally do to relieve your symptoms:

____

____

____

My biggest problem with sleep is… *(please check the* ***MOST*** *bothersome symptom)*
☐Falling asleep ☐Frequent waking up throughout the night ☐ Feeling unrefreshed in the morning

Overall Health

In general, would you say your overall health is:
☐Excellent ☐Very Good ☐ Good ☐ Fair ☐Poor

Patient Name:______________________________ DOB:__________ Date:________

Male Health History

Has a healthcare provider every diagnosed you with any of the following medical conditions? *(please circle Y-yes or N-no)*

Condition		
Benign prostatic hypertrophy....................	Y	N
Prostate cancer....................	Y	N
Testicular cancer....................	Y	N
Any other type of cancer or blood disorder?	Y	N

If yes, what type of cancer or blood disorder?

Condition		
Fibromyalgia....................	Y	N
Osteoporosis or osteopenia....................	Y	N
Thyroid disorder....................	Y	N
Diabetes....................	Y	N
Epilepsy/seizure disorder....................	Y	N
Erectile Dysfuntion....................	Y	N
High blood pressure....................	Y	N
Liver disease....................	Y	N
Gastrointestinal Absorption Disorder (GERDS/heartburn)....................	Y	N

SYMPTOMS ASSESSMENT

Please review each category and mark which symptoms have been bothersome on a scale of 1 through 4.

1- no symptoms 2-minimal 3-moderately 4-severe

Symptom				
Extreme Fatigue/tired or feeling exhausted....................	1	2	3	4
Urinary frequency....................	1	2	3	4
Lack of energy/endurance....................	1	2	3	4
Depression....................	1	2	3	4
Headaches and/or migraines....................	1	2	3	4
Rapid mood changes/mood swings....................	1	2	3	4
Lack of sex drive/libido/sexual desire....................	1	2	3	4
Difficulty having/maintaining erections	1	2	3	4
Hot flashes/night sweats....................	1	2	3	4
Bloating/water retention....................	1	2	3	4
Difficulty falling and staying asleep....................	1	2	3	4
Memory problems/forgetfulness....................	1	2	3	4
Acne/oily skin....................	1	2	3	4
Loss of body hair....................	1	2	3	4
Increased anxiety....................	1	2	3	4
Increased irritability and/or anger....................	1	2	3	4

How strong are your morning erections: ☐ Very hard and erect ☐ Somewhat hard and erect

☐ Not that hard ☐ I hardly have morning erections ☐ I do not have morning erections

Patient Name:________________________ **DOB:**__________ **Date:**________

Female Health History

Gynecological History

Date of last PAP smear? _______________

Date of last mammogram?_______________ Results of mammogram:_____________

Date of last pelvic/abdominal ultrasound?_______________Results of ultrasound:_____________

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have ____________________		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have ____________________		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes, or lumps in your breast?		
Have you ever needed to do a breast ultrasound? If yes, what was the reason for the test?		
Are you using a birth control method? If yes, what kind?		
Are you still having menstrual periods? If yes, when was the **first day** of your **last period**? **LNMP:**______________________________		

Menstrual Period History

Please describe any problems you have with your periods, or have had (if you are now menopausal):

Periods are (were): regular irregular painful crampy heavy light other

Age periods began:________ # days of bleeding________ cycle length (days) ________

If you are no longer having periods, at what age did your periods stop? __________________
If your periods stopped less than one year ago, how many months ago was your last period? ________
If you are now deemed menopausal, have you ever had any episodes of vaginal bleeding or spotting?
If yes, when did this occur and for how long? ____

Did your periods stop because you had a hysterectomy? Yes No

- If yes, what was the reason for the surgery? ____________________________
- Were the ovaries removed at the same time? Yes No Not Sure

Patient Name:______________________________ DOB:__________ Date:________

Female Health History

Cancer History

☐ (check if no to all)

Do you have a history of any of the following cancers or were you ever investigated for abnormalities in any of the following systems/anatomical sites:

☐ Thyroid
☐ Uterus
☐ Vagina/Vulva
☐ Cervix
☐ Ovarian
☐ Fallopian Tube
☐ Breast
☐ Colon
☐ Other: ______________________________________
____

FEMALE SYMPTOMS ASSESSMENT

Please review each category and mark which symptoms have been bothersome by using the scale of 1 through 4. Please rate the level at which you experience the following symptoms. If your symptoms fall between numbers, choose the higher one.

Symptoms (Females only)	1 none	2 Minimal	3 Moderate	4 Severe
1. Fatigue/tired and or always exhausted				
2. Coffee/energy drink withdrawals				
3. Food cravings—carbs/salty/sweet				
4. Lack of energy or endurance				
5. Depression, feeling sad, low moods, tearful/crying				
6. Moodiness, rapid mood swings/mood changes				
7. Irritability or increased anger/hostility to others				
8. Increased anxiety or increased worrying				
9. Lack of sex drive/libido/sexual desire				
10. Vaginal dryness/irritation				
11. Pain with sex				
12. Breast tenderness, sore/swollen breasts, breast changes/lumps, or fibrocystic breast disease				
13. Bloating/water retention or swelling (edema)				
14. Headaches and/or migraines				
15. Forgetfulness/memory problems				
16. Brain Fog/Difficulty focusing/trouble thinking				
17. Acne or pimple skin problems				
18. Hair on face/chin—excessive hair on body				
19. Thinning hair or hair loss				
20. Weight gain or difficulty losing weight				
21. Loss of skin tone and/or increased wrinkles				

Patient Name:_____________________________ **DOB:**__________ **Date:**________

Symptoms (Females only)	1 none	2 Minimal	3 Moderate	4 Severe
22. Increased skin injuries/thinner skin				
23. Muscle weakness and/or loss of strength				
24. Weight loss				
25. Brittle nails, cracked dry nails, nail changes				
26. Cold intolerance/wearing more clothing than others				
27. Heat intolerance—finding it's always too hot				
28. Dry skin				
29. Constipation				
30. Diarrhea/Loose stools				
31. Difficulty handling stress, freaking out at times				
32. Warm or flushed skin				
33. Nervousness, heart palpitations, pounding/irregular heartbeats				
34. Hand tremors/shakiness				
35. Excessive sweating				
36. Decreased motivation				
37. Decreased ability to be aroused/have orgasms or decreased sexual pleasure				
38. Difficulty falling or staying asleep, insomnia				
39. Snoring when asleep, sleep apnea				
40. Heavy and/or irregular periods				
41. Abdominal cramps				
42. Premenstrual disorder (symptoms days before menses)				
43. Breast less full and/or sagging				
44. Hot flashes/night sweats/nuclear meltdowns				
45. Low back pain or joint pain				
46. All over body aches and pain, chronic pain syndromes				

Have these symptoms occurred roughly at around the same time each month (cyclically)? ☐

Or have these symptoms occurred more randomly throughout the month? ☐

Patient Name:____________________________ DOB:__________ Date:________

GENERAL HEALTH HISTORY

System Review – Check the appropriate box for each question.			
General Health Condition	**Yes**	**No**	**Not Sure**
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Do you have morning joint pain and stiffness lasting more than one hour?			
Have you been diagnosed with any inflammatory/auto-immune conditions? If yes, which one(s):			
Do you suspect that you may have any inflammatory/auto-immune conditions? E.g. Lyme borealis disease, Lupus			
Do you suspect that you may have a health condition? If yes, which one?			
Have you ever been or feel you have been exposed to mold?			
Respiratory	**Yes**	**No**	**Not Sure**
Do you have a persistent cough?			
Do you have recurrent sinus infections?			
Do you have excessive daytime sleepiness?			
Do you snore? If yes, do you sleep with a CPAP machine? Y__N__			
Have you ever been diagnosed with asthma, COPD or emphysema?			

System Review – Check the appropriate box for each question.			
Cardiovascular	**Yes**	**No**	**Not Sure**
Do you have chest pain?			
Do you have heart palpitations or often feel your heartbeat skipping?			
Do you have shortness of breath when walking/doing activities?			
Do you have unexplained swelling in your feet/ankles or in your arms?			
Do you experience pain or swelling in your leg calves?			
Vascular disease or artery blockages/aneurysms?			
Aortic stenosis, heart valve issues, heart murmurs?			
Have you been diagnosed with any heart condition?			
Have you ever needed a stress test/cardiac test? Note: we will need copies of these tests.			
Have you ever been diagnosed with a blood clot or a bleeding/platelet disorder?			
Have you ever had an issue with your cholesterol levels?			

Patient Name:______________________________ **DOB:**___________ **Date:**_________

System Review – Check the appropriate box for each question.

Gastrointestinal	Yes	No	Not Sure
Do you have problems swallowing food? Choking symptoms?			
Do you have nausea or vomiting?			
Do you have diarrhea? Or constipation? (circle which one)			
Have you ever had blood in your stool?			
Do you have abdominal discomfort with bloating and gas?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine	**Yes**	**No**	**Not Sure**
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated blood sugar? Diabetes?			
Are you excessively thirsty?			
Do you have any concerns of excessive or lack of normal hair distribution? e.g. on scalp or chin			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem or told you have a borderline thyroid disorder?			
Neurological	**Yes**	**No**	**Not Sure**
Do you sometimes have muscle weakness or difficulty walking?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Have you ever been diagnosed with any neuromuscular condition? E.g. multiple sclerosis, Parkinson's, tremors			
Do you have concerns of numbness or tingling in your extremities or hands/feet?			
Urologic / Renal	**Yes**	**No**	**Not Sure**
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others or than before?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems? E.g. cysts or stones?			
Musculoskeletal	**Yes**	**No**	**Not Sure**
Have you ever broken/fractured a bone? If yes, please provide the date and location of fractures			
Do you walk with a cane or a mobility aid?			
Have you been diagnosed with osteoporosis or osteopenia?			
Have you used progestins for a duration greater than 1 year? e.g. Depo-provera			
Have you ever been in a serious motor vehicle accident?			

Patient Name:______________________________ **DOB:**__________ **Date:**________

Disclosure / Liability Waiver

I would like to take this opportunity to welcome you to the services of Kayla Adebajo, Nurse Practitioner and Advanced Bio-Identical Hormone Specialist. Kayla's practice utilizes the principles of both Conventional Medicine and Alternative Medicine to assist the body's own ability to heal and thrive. A number of different Integrative Medicine approaches may be used, and may include: Prescribing of Bio-Identical Hormones and other medications, Clinical nutrition and Nutritional supplements, Botanical/Herbal Medicine, Acupuncture, Stem Cell/PRP joint injections, Physical Medicine, Intravenous Therapy, Lifestyle Counselling, psychotherapy and neurolinguistic programming. These above therapies are not covered by OHIP. The majority of the laboratory blood tests are covered by OHIP.

The use of Integrative Medicine therapy approaches and the use of bio-identical hormones are viewed as medically unnecessary or as experimental medicine. Integrative Medicine is not recommended to be used solely to treat medical conditions. Bio-identical hormone therapy, is an off-label therapy used for symptoms of andropause, menopause, low energy, and mood symptoms.

Many Integrative Therapies and use of bio-identical hormone therapies are being provided to lessen or treat non-life threatening symptoms you have identified as bothersome, and undesirable. You are also aware that there are a number of available prescription hormone replacement therapy you can receive from your primary healthcare provider, however you prefer to be treated by a practitioner with specialty advanced certification in the area of bio-identical hormone replacement therapy. Our clinic prefers to prescribe bio-identical hormones from a compounded pharmacy to ensure individualization of therapies to effectively treat your symptoms.

Although Integrative Medicine uses a more natural approach to therapies, even these may induce complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly and in certain conditions including but not limited to diabetes, liver, heart or kidney disease. It is therefore important to inform your Practitioner of any illnesses you suffer from or medications you may be taking (prescription or over-the- counter). If you are a female and are pregnant, suspect you may be pregnant or are nursing, please advise your Practitioner immediately.

While numerous safety measures are taken to ensure the best health outcomes. Incidental events may occur that are beyond the control of our staff. Your practitioner will review your completed medical and case history with you. As part of a comprehensive intake assessment, a physical exam, release of past records, and/or specific laboratory tests (blood and/or urinary) may be required and used as part of the treatment plan and as deemed necessary.

The slight health risks of some Integrative Medicine therapies may include, but are not limited to: aggravation of pre-existing symptoms or conditions, allergic reaction to medications, supplements or herbs; and pain, fainting, bruising or injury from injections, acupuncture, or IV therapies.

You are participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result.

Patient Name:_______________________________ DOB:___________ Date:_________

Disclosure / Liability Waiver cont'd

Below are details of your understanding:

- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
- 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 without my consent, unless required by law.
- I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.
- I understand that my practitioner will answer any questions I have to the best of her ability.
- I understand that the results are not guaranteed. With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments of Integrative Medicine and Bioidentical Hormones.
- I understand that treatment advice may be given over the phone, email, Zoom, Skype or any other telemedicine communication platform. I consent to the use of telecommunication as part of my care.
- I understand that I must continue services with my Primary Health Care Provider and other specialists in my care. Services provided by Kayla Adebajo, NP-PHC are not to replace your family doctor.
- I understand that regular preventative tests typically carried out by my Primary Health Care Provider may be requested as part of participation in integrative medicine care. This may include yearly ultrasounds.
- I accept full responsibility for any fees incurred during care and treatment.
- I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment.
- I also understand that the Cancellation policy requires me to cancel and/or reschedule a booked appointment 24 hours prior to a given, scheduled appointment. Cancellations with less than 24 hours notice will incur a charge of 50% of the scheduled office visit fee that must be paid prior to the next visit.

I have read the above and all of my questions have been answered to my satisfaction. This consent form is intended to cover the entire course of treatment for my present condition. I attest that I have truthfully completed the health history intake form and have declared all of my known medical conditions. I accept all terms and conditions of this program and I am consenting to participate voluntarily in this treatment program. By signing, I waived any claims or rights I might have to pursue legal action against the treating practitioner and staff involved for any possible incidents or injury that may occur while participating in this program as outlined above as Integrative Medicine.

Patient Name: ____

Patient Signature: ____________________________________ Date:_______________

MD/NP Signature: ____________________________________ Date: _______________

Patient Name:____________________________ **DOB:**__________ **Date:**________

Release of Information (ROI) Form

Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I,______________________________, **authorize**_______________________________
(Print your name) *(Print name of health information custodian)*

to disclose:

My personal health information consisting of: (as ticked of in boxes below)

☐Labs/Diagnostic Imaging ☐Surgical Records ☐Specialist Consult Notes ☐ Discharge Summary

☐ All Records: All of my health information that the provider/health information custodian has in their possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

AND DATED FOR:____

Or

☐ Other as described:

____
____
____

Term: I understand that this Authorization will remain in effect:

- ☐ From the date of this Authorization until the______day of_________, 20_____.
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:____

To:

KAYLA ADEBAJO, NP-PHC
Urban Integrative IV and Detox Clinic
615 Yonge Street, 6th Floor
Toronto, Ontario, M4Y 1Z5
Telephone (416)463-2911 • Fax 1(888) 676-2476

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

Patient's Legal Full Name:____
Date of Birth:________________________**Address:**_____________________________________
Home Tel.:__________________________**Cell Tel.:**____________________________-_________
Signature:___________________________**Date:**____

Witness Name:_______________________**Address:**______________________________________
Home Tel.:__________________________**Work Tel.:**_____________________________________
Signature:___________________________**Date:**____