Pro-Forma: GP Report on Patient Claiming Concern/Harm from Electromagnetic Radiation (EMR)

Dr.___________________________________

Clinic Name:__________________________

Address:_____________________________

____

Phone:______________________________

Email:_______________________________

Date:_______________________________

To Whom It May Concern

*(*Strike Out if inapplicable)*

MEDICAL PRACTITIONER IDENTIFICATION

I am a Medical Practitioner with ___________ years of practical experience.

I am a *G.P. / *Integrative Doctor / *Physician / *Medical Specialist. My fields of medical specialty include : *(if specializing):* ____

____

PATIENT IDENTIFICATION

The Patient, *Mr/Mrs/Ms/Ma., _______________________________ aged ___________ years, attended for appointment at my consulting rooms on _____________ indicating health / medical concerns relating to their fear of Electromagnetic Radiation (“EMR”) (also known as Non-Ionizing Radiation “NIR”) in their *Home/Workplace/Educational Institution/Everyday Environment. (“Environment”).

____

I understand my role in completing and signing this Form/ Report is NOT TO DIAGNOSE WHETHER MY PATIENT actually suffers from Electromagnetic Hypersensitivity (EHS) or other discernible medical condition recognized by the Mainstream ______ *(sign initials)*

My role is ONLY TO CONFIRM that my Patient has:

(a) RATIONIZED FEAR OF EMR ______ *(sign initials) &*

(b) A REASONABLE FEAR OF RISK OF HARM TO THEIR HEALTH from EMR in their Environment ______ *(sign initials) &*

(c) CLAIMS TO BE EXPERIENCING certain symptomologies or health effects as a result of that EMR that may include Thermal (heating) and Non-Thermal (biological) effects of EMR and NIR ______ *(sign initials).*

The Patient *has/*has not asked for a referral to a medical specialist.

As the Patient's Medical Practitioner, I *have/ *have not referred the Patient for Specialist Medical attention as a result of this consultation.

(If Specialist Referral is indicated). To what kind of Medical or other Specialist: __________________

The Patient to sign:

I, __________________________________*(Patient)* hereby waive my rights to Doctor/Patient confidentiality with respect to this Pro-Forma and this consultation with my doctor.

The Medical Practitioner to sign:

I, Dr.___________________________________, Hereby sign this Pro-Forma knowing the contents hereof to be True to the best of my knowledge, information and belief.

DATED THIS _______________day of ___________________20____