VITALIZED PERFORMANCE GROUP

860-430-2342 voice
860-430-2843 fax
vpgwaves@vpgwaves.com

212 New London Turnpike, Suite D
Glastonbury, CT 06033

"Prescription" for Colon Hydrotherapy Services

Patient _____ DOB:_____

The client named above gives permission to view a health history questionnaire and other documents and to be consulted by the undersigned in-person or gives permission to MD/ND/APRN to consult with another licensed healthcare provider who conducted an in person consultation prior to approving Colon Hydrotherapy services. Such approval, if any, may be confirmed by a "prescription" from the reviewing MD/ND/APRN to the client and the Colon HydroTherapist.

The state of CT requires DO/MD/ND/APRN to approve Colon Hydrotherapy prior to the 1st treatment.

The undersigned physician approves Colon Hydrotherapy services for the above-named client; *provided, however,* that this approval shall automatically be rescinded when the client informs the Colon HydroTherapist of any change to the information contained in this form and changes to the patient intake. Approval will only be reinstated after the undersigned or another reviewing Naturopath/MD/APRN has reviewed such change and approved the continued performance of Colon Hydrotherapy.

Reviewing naturopathic physician signature

Linda Sparks, N.D. _____ _____(date)

Or:

Reviewing independent licensed healthcare provider:

_____(signature) _____(date)

_____ (please print name)

Additional Notes by physician (optional):

_____

_____