



# MEMBERSHIP REFERRAL SURVEY 2012

Return your completed survey to the OAND by fax (416-233-2924), scan your completed survey and email to memberadmin@oand.org or mail to OAND, 789 Don Mills Rd, Suite 603, Toronto, ON, M3C 1T5.

*As a benefit of membership, the OAND maintains a referral database that is used for both online and telephone inquiries from members of the public seeking referrals to an ND. The OAND strives to give our members the best referrals we can; the more information we have about your practice(s), the more effectively the referral system works.*

Please complete this survey carefully and be sure to include an answer for every section (yes or no):

Name (Last): \_\_\_\_\_ Name (First): \_\_\_\_\_

Do you offer home visits to your patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you practice in more than one language?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, list languages: - - - - -		

**Do you offer any of the following therapeutic approaches in your practice?**

Nutritional Counselling	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Botanical Medicine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Homeopathy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Spinal Manipulation	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Physical Medicine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
TCM	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Acupuncture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Counselling	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Do you employ any of the following therapies/tests?**

Parenteral Therapy (BDDT-N Certified)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Vega / EAV / Electro-Diagnosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
UV / Ultrasound / Physical Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Thermography	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Infra-Red Sauna	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Injectibles – Vitamin, Mineral, Homeopathic, Botanical	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hydrotherapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Darkfield Microscopy / Live Blood Cell Analysis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Colonics	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bowen Technique	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Body Work	<input type="checkbox"/> YES	<input type="checkbox"/> NO
NAET	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Craniosacral	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Drainage	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Magnetic Field Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Applied Kinesiology	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Blood / Urine Testing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Iridology	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Reiki Therapy	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Please indicate below the ailments/health issues for which you have specialized training and/or experience. Check all that apply and add comments as to training and/or experience. Please note that training and experience must be listed for inclusion in the referral database.**

	Yes?	Training	Experience
Cancer	<input type="checkbox"/>		
HIV	<input type="checkbox"/>		
Colitis / Crohns / IBS	<input type="checkbox"/>		

	Yes?	Training	Experience
Arthritis	<input type="checkbox"/>		
Endocrinology	<input type="checkbox"/>		
Chronic Fatigue	<input type="checkbox"/>		
ADD / Hyperactive	<input type="checkbox"/>		
Fibromyalgia	<input type="checkbox"/>		
Allergies	<input type="checkbox"/>		
Skin Conditions	<input type="checkbox"/>		
Sports Medicine	<input type="checkbox"/>		
Cardiovascular Disease	<input type="checkbox"/>		
Palliative Care	<input type="checkbox"/>		
Women's Health	<input type="checkbox"/>		
Men's Health	<input type="checkbox"/>		
Fertility / Prenatal Support	<input type="checkbox"/>		
Geriatrics	<input type="checkbox"/>		
Neurological Disorders	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>		
Weight Management	<input type="checkbox"/>		
Paediatrics	<input type="checkbox"/>		
Mental / Emotional Disorders	<input type="checkbox"/>		
MS	<input type="checkbox"/>		
Pain	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>		
Other (please specify):			