



WILDE INTEGRATION

wildeintegration.com | Dr. Sarah P. Wilde, GPC, AP

GERSON THERAPY ELIGIBILITY CRITERIA FORM

After completing this form, please send to: **SarahPWilde@protonmail.com**
Thank you.

NAME:	DATE (MM/DD/YYYY):
PHONE NUMBER: EMAIL ADDRESS (for communication between doctor and client):	
GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (MM/DD/YYYY):
MEDICAL DIAGNOSIS (if cancer, include the stage. If metastatic, include where it has spread):	

PLEASE ANSWER NEXT TO THE QUESTIONS BELOW AS **YES, NO, OR N/A** (NOT APPLICABLE). YOU MAY PRINT OUT, COMPLETE, TAKE A PHOTO OR SCAN TO YOUR COMPUTER AND EMAIL OR FAX BACK

1. Is your diagnosis cancer or benign but space occupying tumor?
2. Is your diagnosis ALS, Parkinson's, Alzheimer's, Emphysema, or Muscular Dystrophy?
3. Is your diagnosis melanoma that has spread to the brain?
4. If you have pancreatic cancer, have you received or plan to receive chemotherapy?
If yes, how many sessions?
5. If your condition is regarding cancer, do you have an open wound (draining or non-draining) or an ulcerated skin (draining or non-draining) related to the cancer?
6. Are you a smoker?
7. Have you recently quit smoking within the last year?
8. Are you on kidney dialysis, or have you received organ transplant?
9. Have you received or will receive a stem cell transplant?

10. Have you and/or are you receiving long-term steroid medication (eg. Prednisone) greater than 3 months?
11. Are you able to eat normally (i.e. chew and swallow, and no feeding tube or stomach tube)?
12. Are you able to drink normally (i.e. via the mouth, and no feeding tube or stomach tube)?
13. Are you able to have a bowel movement normally (i.e. no bowel obstruction, and no colostomy)?
14. Are you able to urinate (i.e. no renal failure)?
15. If you have cancer, are you still working?
16. If you are working, are you working at home (i.e. office at home)?
17. If you have cancer, are you less than the age of accountability (less than 18)?
18. Do you have the financial means to cover the expenses? (Gerson Therapy is NOT covered by health insurance)
19. Do you have high speed internet access with a web cam on your computer (this is a requirement)? (Note: All consultations are done via web-based high definition video conferencing or meeting. No traveling necessary. A good web video tool is Zoom Cloud Meeting – sign up for a free account at www.zoom.us)
20. Do your spouse or significant other and/or immediate family support your decision?
21. Do you have a family doctor (or oncologist) willing to provide support for your medical needs (prescription meds including Armour Thyroid or the equivalent and Vitamin B12 shots, order some or all the labs, order advanced imaging such as MRI or CT or PET/CT or Ultrasound or Mammogram) when indicated while on the Gerson Therapy?
22. If you have cancer, are you prepared to purchase (or do you already own) a Norwalk Juicer or the cheaper version (Champion Juicer + The Juice Press)?
23. I have read the book, Healing the Gerson Way (or other materials) and have a basic understanding of what is involved in committing to the Gerson Therapy.
24. I have talked with the Gerson Institute staff (800-838-2256) about the Gerson Therapy, have reviewed their website have all my questions answered.
25. I have read the book, Healing the Gerson Way explaining the contraindications for doing the therapy and I understand which conditions require caution and which conditions do not respond well to the Gerson Therapy.
26. I have discussed the nature of my diagnosis with my medical doctor and I am fully aware of the extent and the stage of my disease.



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27. My health prognosis has been discussed with me by my medical doctor including what would happen if I do nothing and within what time frame.

28. I have been told by my medical doctor what conventional treatment options are recommended for my diagnosis, as well as the best expected outcome and the worst expected outcome using these standard treatments.

29. I have done my own research regarding my condition, which has augmented my understanding of my diagnosis and prognosis

30. I am aware that the Gerson Therapy is a nutritional program designed to restore health and immune system and that this process takes time.

31. I am aware that it could take 3-4 months before I will have a good indication of whether the therapy is making a significant impact on my condition. I understand that periodically I will need to assess whether I am making sufficient progress and that it is possible that my Gerson practitioner may recommend that I consider integrating other alternative or conventional approaches Note: An average of 9-12 month window is needed to see the disease slow down, stop or reverse itself.

32. I have realistic expectations of what the Gerson Therapy may accomplish and know that how closely and accurately I can adhere to my Gerson treatment protocol will impact my chances of a favorable response.

33. I understand that any compromise to carrying out the therapy accurately, such as continuing to work (if with cancer diagnosis) and not having help and support at home, will lessen my chances of a positive response or success in reaching my goal.

34. I am aware that I will need to get lab work regularly (usually monthly for cancer therapy) after the initial baseline lab work in the first year and then every 6-8 weeks in the second year in order for my practitioner to monitor my response to my treatment protocol and make any needed adjustments. I may also need follow-up diagnostic imaging (CT or MRI or PET/CT or US or Mammogram) to determine the interval change of what is happening inside me compared to the initial baseline imaging.

35. I am prepared to take full responsibility for my decisions and actions. I realize the importance of taking personal responsibility for carrying out the Gerson Therapy correctly and to the best of my ability as prescribed by my Certified Gerson Practitioner. I understand that I will work in partnership with my practitioner.

36. I understand that this home Gerson Therapy program is very work intensive and might need family members to help or hired help.
37. I am aware of the online Gerson Basics Workshop that I can sign up for at the www.gerson.org website to help me with the home set up and also provide technical information aspects of the program.
38. I am also aware of the services of Gerson-Certified Home Set up Trainers whose service I can employ to help set up my home, kitchen and instruct me and/or my designated help to be organized and efficient to run the home Gerson Therapy (to learn more about this Home Set-up Trainer service you can ask your Gerson Practitioner or contact the Gerson Institute assistance at www.gerson.org).
39. I fully understand that there are no guarantees that the Gerson Therapy will completely resolve my health condition.
40. I understand that even if I am following the Gerson Therapy correctly and with guidance from the Gerson Practitioner, my body MAY NOT RESPOND to health improvement or I may not fully recover from the disease process for unexplained reasons. I will accept the consequence of NO IMPROVEMENT.
41. I understand that either party (Gerson Practitioner or myself or my designated Power of Attorney) may discontinue or terminate the team partnership at any time for any reason.
42. I understand that I am in charge of my own health path and I take full responsibility for my choice of action in doing the Gerson Therapy under professional guidance.
43. I understand that if I am pre-approved for guidance in the Gerson Therapy and I decide to pursue the guidance service that ALL financial responsibilities (procedures, supplements, equipment, food and services employed) rests on me.
44. I also understand that if I am pre-approved for guidance in the Gerson Therapy and I decide to pursue the guidance service of the Gerson Practitioner that I will waive or relinquish my Gerson Practitioner or any affiliated institution or parties from any claims, liabilities or legal actions whatsoever that may arise from recommendation and/or services or guidance rendered to me because I am fully responsible for my choice and actions.
45. I understand and agree that if I am found to be dishonest regarding my answers of any of the above questions or statements (#1-#45) that my Gerson Practitioner has the right to terminate the management of my case immediately or at a designated date.
46. I also understand that if I am found to be controlling, coercive, demanding, abusive, disrespectful, making derogatory remarks, and/or employing offensive



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language or profanity or any malicious intent to discredit my Gerson Practitioner (personally, publicly or social media) during the course of managing my case, or if my Gerson Practitioner deems or perceives any of the above, then any or all of the above are grounds for immediate dismissal or termination from the case management or guidance in the Gerson Therapy. I will fully comply with the dismissal and will not contest or hold it against my Gerson Practitioner or any affiliated institution or parties. I fully understand the seriousness of the described inappropriate and negative behaviors as stated above are not tolerated in this professional service.

PRINTED NAME OF
APPLICANT _____

APPLICANT
SIGNATURE _____
(LEGALLY BINDING HANDWRITTEN SIGNATURE IS REQUIRED)

PRINTED NAME OF
WITNESS _____

SIGNATURE OF
WITNESS _____
(SIGNIFICANT OTHER, FAMILY MEMBER OR DESIGNATED POWER OF ATTORNEY)

DATE _____

Note: Returning this completed form WITH SIGNATURE AND DATE will be construed as a legal document personally completed, reviewed and approved by the client.