PAARL INFUSION CENTRE

IV Therapy Consent Form

Patient Name: _____ Birthdate: _____ Date: _____

Primary Care Physician: _____

Current health conditions:

_____

_____ ____

Current medications (if not a Wellness patient of aNu):

_____

_____ ____

Date of last blood test/physical exam: _____

Past medical history (check all that apply):

Hypertension _____	Angina _____	Ankle swelling _____
Arrhythmia ____ Abnormal	CHF _____	Heart attack _____ Generalized
EKG _____ Bleeding	Kidney Disease _____	edema _____ Pulmonary
disorder _____ Sudden	Asthma _____	edema _____ Anxiety or panic
weight loss _____ **G6PD**	Diabetes _____	attacks _____
deficiency _____		

Give pertinent details of conditions listed above:

_____

_____

Medication, food, or other allergies:

_____

Allergic reactions if allergies listed above (please explain):

_____

Are you currently pregnant? _____ Are you breastfeeding? _____

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Patient Name: _____

Ordering Provider: _____

1) You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.
    a) The procedure involves inserting a needle into your vein or muscle and injecting the formula described above by your physician.
    b) Alternatives to intravenous therapy is oral supplementation and/or dietary and lifestyle changes.
    c) Risks of intravenous therapy include:
        i) Discomfort, bruising, and pain at the site of injection.
        ii) Inflammation of the vein used for injection, phlebitis.
        iii) Severe allergic reaction, anaphylaxis, cardiac arrest and death.
    d) Benefits of intravenous therapy include:
        i) Injectables are not affected by stomach or intestinal disease.
        ii) Total amount of infusion is available to the tissues.
        iii) Nutrients are forced into the cells by means of a high concentration gradient.
        iv) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

2. You have the right to consent to or refuse the proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedure(s) described above with any different or further procedures which, in the opinion of your physician, may be indicated.

3. The procedure will be performed by or under the direction of the physician named above with qualified registered nurses.

Your signature below means that:

1. You understand the information provided on this form and agree to the foregoing.
2. The procedure(s) set forth above has been adequately explained to you by your physician.
3. You have received all the information and explanation you desire concerning the procedure.
4. You authorize and consent to the performance of the procedure(s).

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____