iCare Health Services

IV Informed Consent

Patient Name: _____

Date: _____

This document is intended to serve as confirmation of informed consent for IV therapy and ordered by the provider at iCare Health Services.

I have informed the physician of any known allergies to drugs or other substances, or of any past reactions to anesthetics. **Initials:** _____

I have informed the physician of all current medications and supplements. **Initials:** _____

I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. **Initials:** _____

Except in emergencies, procedures are not performed until I have had the opportunity to receive such information and to give my informed consent.

Side Effects & Risks

I understand that:

- The procedure involves inserting a needle into a vein and injecting the prescribed solution.
- Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
- Risks of intravenous therapy include but are not limited to:
    - Occasionally to commonly:
        - Discomfort, bruising and pain at the site of injection.
        - General feeling of warmth during and after injection.
    - Rarely:
        - Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
        - Reactive Hypotension (or rapid drop in blood pressure)
        - Reactive Hypoglycemia (or rapid drop in blood sugar)
    - Extremely rarely:
        - Severe allergic reaction
        - Anaphylaxis
        - Infection
        - Cardiac arrest
        - Death

Initials: _____

iCare Health Services IV Therapy Consent

Benefits of intravenous therapy include:

- Injectables are not affected by stomach or intestinal absorption problems.
- The total amount of infusion is available to the tissues.
- Nutrients are forced into cells by means of a high concentration gradient.
- Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

The Procedure

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period, prescribed nutrients (vitamins, minerals, amino acids) or chelation agents. Your vitals will be measured prior to and after your infusion.

What safety precautions must you take?

- Monitor the insertion site for signs and symptoms of infection (redness, swelling, discharge). Notify the clinic immediately. If you experience a sustained fever greater than 101, do not delay treatment and go to the ER as this can be a sign of sepsis.

- If you experience a minor side effect while you are at home you should contact the front desk at 301- 300-8624, otherwise, contact your medical provider or call 911.

My consent for nutrient infusion therapy is voluntary

My request for nutrient infusion therapy as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse treatments at any time. **Initials:** _____

Financial Responsibility

I am aware/notified that IV infusion/s are self-pay services. IV therapy is not billed through insurance and payments are due at the time of services**. Initials:** _____

Statement of person giving informed consent

I have read this consent form and understand the information contained in it. I understand the risks and benefits and have had the opportunity to have all my questions answered to my satisfaction. I am aware that other unforeseeable complications could occur. I do not expect the provider(s) to anticipate and explain all risks and possible complications. I rely on the provider(s) to exercise judgment during treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all my questions were answered. I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I give my consent to IV nutrient therapy.

Patient Name: _____Date: _____

Signature: _____

Witness: _____Date: _____ Signature: _____

Release of medical information

I hereby authorize _____ to disclose my medical records, to EMS, my spouse, and emergency contact. I also authorize _____ to discuss my care and share my medical information for the purposes of monitoring, quality control or safety concerns

Patient Signature: _____ Date: _____