Valley Natural Health

Informed Consent for Intravenous (IV) Therapy

This document is intended to serve as confirmation of Informed Consent for IV therapy as ordered by p hysician at Valley Natural Health.

(Initials)_____I have informed the physicians/nurse of any known allergies to drugs or other substances, or of any past reactions to anesthetics.

(Initials)_____I have informed the doctor/nurse of all current medications and supplements

I understand that I 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 I have had the opportunity to receive such information and to give my informed consent.

I understand that:

1. The procedure involves inserting a needle into a vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids).
2. Alternative to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:
    - Discomfort, bruising and pain at the site in injection.
    - Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    - Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
4. Benefits of Intravenous Therapy include:
    - Injectables are not affected by stomach, or intestinal absorption problems
    - 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

I am aware that other unforeseeable complications could occur. I do not expect the physician/nurse to anticipate and or explain all risks and possible complications. I rely on the physician/nurse to exercise judgement during the course of treatment. I understand the risks and benefits of IV therapy and have had the opportunity to have all of my questions 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 have given my consent to IV Therapy with any different or further procedures which, in the opinion of my physician/nurse may be indicated.

I understand the information provided on this form and agree to the foregoing. I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. I understand that I am free to withdraw my consent and to discontinue participation in IV Therapy treatments at any time.

My signature below confirms that:

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

Patient Name- Print	Patient's Signature	Date _____/_____/___
Physician Name-Print	Physician Signature	Date _____/_____/___
RN Name - Print	RN Signature	Date _____/_____/___