Informed Consent for Intravenous (IV) Therapy

NAME ____ **Date** ______/_______/________

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by Bay Health & Wellness.

(Initials) _______ I have informed the nurse of any known allergies to drugs or other substances that may be included in the ingredients of my solutions, or of any past reactions to anesthetics.

(Initials) _______ I have informed the nurse of all current medications and supplements.

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, and amino acids).

I understand that risks, benefits and alternatives to IVs may include but are not limited to:

1. **The Risks and potential side effects**

○ Discomfort, bruising, and pain at the site of injection.
○ Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
○ Severe reaction, anaphylaxis, cardiac arrest, or death.

2. **The Benefits**

○ Injectables are not affected by stomach or intestinal disease.
○ Total amount of infusion enters the bloodstream and is available to the tissues
○ Higher doses of nutrients can be given by vein than by mouth without intestinal irritation that can accompany doses given by mouth.

I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

I understand that there is no implied or stated guarantee of success or effectiveness of any treatment. The procedures set forth above has been adequately explained to me by my physician.

I understand that I will incur the full fee for treatment. My signature below confirms that:

1. I have received all the information and explanation I desire concerning the procedure.
2. I authorize and consent to the performance of the procedure(s)

Print Patient Name: ____

Patient Signature: ____