Community NP

IV HYDRATION CONSENT FORM

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by the medical provider at Community NP.

(Initials)_____ I have informed the medical provider at Community NP of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials)_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

(Initials)_____ 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 an opportunity to receive such information and to give my informed consent.

(Initials)_____ I understand that: 1. The procedure involves inserting a needle into a vein and injecting the prescribed solution. 2. Alternatives to intravenous therapy are oral supplementation and / or dietary and lifestyle changes. 3. Risks of intravenous therapy include but not limited to: a) Occasionally: Discomfort, bruising and pain at the site of injection. b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death. 4. Benefits of intravenous therapy include: a) Injectables are not affected by stomach, or intestinal absorption problems. b) Total amount of infusion is available to the tissues. c) Nutrients are forced into cells by means of a high concentration gradient. d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) and/or physician(s) to anticipate and or explain all risk and possible complications. I rely on the Community NP providers to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

(Initials)_____ 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 Infusion Therapy, including any other procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated. My signature below confirms that: 1. I understand the information provided on this form and agree to all the statements made above. 2. Intravenous (IV) Infusion Therapy has been adequately explained to me by the Community NP provider. 3. I have received all the information and explanation I desire concerning the procedure. 4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy. 5. I release Andrea Gibson, APRN, CMC, Community NP, and all the medical staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.

Patient's Name and Date of Birth: Please Print

_____

Patient's Signature and Date

_____

Community Np Provider Name: Please Print

_____

Community NP Provider Name: Please Print Signature and Date

_____

Community NP

IV HYDRATION THERAPY INTAKE FORM

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Postal Code: _____

Phone: (H) _____(Cell) _____

Date of Birth: _____(YYYY/MM/DD) Age: ____ Sex: M / F / □ _____

Occupation: _____ Email: _____

By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, whom should we contact: _____

How did you find out about our services? _____

Why would you like to receive IV Therapy?

_____

_____

Have you received IV Therapy before? What was your experience like?

_____

_____

Please check if you have any of the following conditions that IV Therapy can help with:

□ Fatigue □ Low Depressed Mood □ Anemia □ Weight Issues □ Irritability/Moodiness □ Trying to get Pregnant/Fertility Prep □ Stress □ PMS □ Allergies □ Sleep Disorders □ Asthma □ IBS/Inflammatory Bowels □ Low Immunity □ Digestive Issues □ Numbness/Tingling of body □ Migraines □ Muscle Spasms

Please list all allergies (known and suspected):

_____

_____

Please list all current and past medical conditions, diagnosis, hospitalizations, surgeries:

_____

_____

Please list all prescription drugs and supplements you are currently taking and doses:

_____

_____

_____

Date of last Physical Exam/Blood Test: _____

Any abnormal results from blood test? _____

Do you have any medical devices implanted in your body? Pins, Plates, Pacemakers?

_____

Please check if you have any of the diagnoses below:

□ High Blood Pressure □ Arrhythmia □ Abnormal EKG □ Low Blood Pressure □ Angina □ MI / Heart Attack □ Diabetes □ Bleeding Disorder □ Ankle Swelling □ Kidney Disease □ Asthma □ G6PD Deficiency □ Anxiety □ Congestive Heart Failure □ Edema □ Sudden Weight Loss □ Cancer

Over the last 2 weeks, how often have you been bothered by the following problems? (Use "X" to indicate your answer)

1. Feeling nervous □ Anxious or on edge □ Not being able to stop or control worrying □ Little interest or pleasure in doing things □ Feeling down, depressed, or hopeless □

Additional notes:

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____