IV Therapy Consent Form (Additional TX)

Patient Name: ___________________________ Birthdate: ____________ Date: ____________

Have any of your medications or chronic medical conditions changed since your last IV? NO / YES

(If yes, please explain in detail and talk to your medical provider prior to treatment)

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) This is an elective procedure.
   b) This procedure involves inserting a needle into your vein and injecting the formula ordered by your medical provider.
   c) Alternatives to intravenous therapy are doing nothing, taking oral supplementation and/or dietary and lifestyle changes.
   d) Risks of intravenous therapy (nutritional, high dose Vit C, NAD, etc), although very rare, may include:
      i) Discomfort, bruising, and pain at the site of injection.
      ii) Nausea, shakes, chills, headache, chest pain, tingling in extremities, lightheadedness.
      iii) Inflammation of the vein used for injection (phlebitis)
      iv) Infection at the site of injection or systemic in the body.
      v) Fluid, sodium, iron or other nutrient overload.
      vi) Blood sugar fluctuations and falsely elevated blood glucose readings.
      vii) Hemolysis with G6PD deficiency.
      viii) Kidney stones.
      ix) Exhaustion or fatigue.
      x) Detox side effects - such as flu like symptoms.
      xi) Severe allergic reaction, anaphylaxis, cardiac arrest and death.
   e) Benefits of intravenous nutritional therapy include:
      i) Injectables are not affected by stomach or intestinal disease.
      ii) Total amount of infusion is available to the tissues (100%).
      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 medical provider, may be indicated.

3. The procedure will be performed by or under the direction of the physician or nurse practitioner of aNu with qualified registered nurses or nurse practitioners.

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 medical provider.
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:** ______________