Intravenous (IV) Infusion Therapy Consent Form

Patient Name:	Patient Date of Birth:
	Date:

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by Dr. Jeffery Edman, MyEnve and Dripp IV Therapy.

I have informed the nurse and / or physician of any known allergies to medications or other substances. I have informed the nurse and / or physician of all current medications and supplements. I have fully informed the nurse and /or physician of my medical/ surgical history. ______**(initial)**

IV infusions 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. _______**(initial)**

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 an opportunity to receive such information and to give my informed consent. _______**(initial)**

I understand that:

1. The procedure involves inserting a needle into the vein and injecting the solution.
2. Alternatives to IV therapy are oral supplements, intramuscular supplements or dietary and lifestyle changes
3. Risks of IV 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 if IV therapy include:
    a) Injectables are not affected by stomach, or intestinal absorption problems
    b) Total amount of infusion is available to the tissue.
    c) Nutrients are forced into cells by means of high concentration gradient.
    d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseen 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 nurse(s) and / or physician(s) to exercise judgement during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have 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 infusion therapy, including any other procedure 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 statements made above.

2. Intravenous Infusion Therapy has been adequately explained to me by my nurse and / or physician.

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 Dr. Jeffery Edman, MyEnve and Dripp IV Therapy, and all the medical staff from all liabilities for any complications or damages associated with my Intravenous(IV) Infusion Therapy.

Patient's Name/ Date of Birth (Print) ____

Patient's Signature and Date ____

Licensed Nurse, APRN or Physician (Print) ____

Licensed Nurse, APRN or Physician Signature and Date ____