Island IV, LLC
PO Box 10650
St. Thomas, VI 00801

Consent Form

I, _____, DOB _____/_____/_____ , hereby authorize the following procedure: administration of intravenous/intramuscular vitamins,minerals, and other nutrients.

(Initials)_____ I have informed the physician of any known allergies to drugs or other substances, or of any past reactions to medications.

(Initials)_____ I have informed the provider of all current medications and supplements.

(Initials)_____ I, understand that I have the right to be informed ofthe 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.

Side Effects/Risks

(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 to commonly:
        i. Discomfort, bruising and pain at the site of injection.
        i. General feeling of warmth during and after injection.
    b. Rarely:
        i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
        ii. Reactive Hypotension (or rapid drop in blood pressure)
        ii. Reactive Hypoglycemia (or rapid drop in blood sugar)
    c. Extremely Rarely: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

Benefits of intravenous therapy include:

1. Injectables are not affected by stomach, or intestinal absorption problems.
2. Total amount of infusion is available to the tissues.
3. Nutrients are forced into cells by means of a high concentration gradient.
4. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

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The Procedure

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids). Your vitals will be measured prior to and after your infusion.

Intramuscular injections involves inserting a needle in the muscular (deltoid, thigh or gluteal) for the injections of prescribed nutrients.

What Safety Precautions Must You Take?

- Monitor the insertion site for signs and symptoms of infection (redness, swelling, discharge). Notify the clinic immediately. If your experience a sustained fever greater than 101, do not delay treatment and go to the ER as this can be a sign of sepsis.
- If you experience a minor side effect while you are at home, you should contact the Nurse, otherwise contact your medical provider or call 911.

My Consent for Nutrient Infusion Therapy is Voluntary

My request for nutrient infusion therapy as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse treatments at any time.

(Initials)_____

Statement of Person Giving Informed Consent

I have read this consent form and understand the information contained in it. I understand the risks and benefits and have had the opportunity to have all my questions answered to my satisfaction. I am aware that other unforeseeable complications could occur. I do not expect the provider(s) to anticipate and or explain all risk and possible complications. I rely on the provider(s) 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. 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 give my consent to IV nutrient therapy.

_____ _____

Patient Phone Number Patient Email

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of my medical records, to EMS, my spouse, and emergency contact. I also authorize the provider to discuss my care and share my medical information for the purposes of monitoring, quality control or safety concerns.

_____ _____

Signature of Patient Date

Copy Provided_____