**ACUPUNCTURE INFORMED CONSENT TO TREAT**

This form (3 pages) and part of the practitioner’s role is to **provide me with information** to assist me in making **informed choices**.

This process is often referred to as **“informed consent” and involves my understanding and agreement regarding the treatment recommended, the benefits and risks associated with the it, the alternatives, and the potential effect on my health if I choose not to receive it.**

**Acupuncture and its associated treatments/ interventions are not intended to substitute for diagnosis or treatment by medical doctors** or to be used as an alternative to necessary medical care.

It is expected that I am under the care of a primary care physician or medical specialist.

It is expected that if I am pregnant, I am being managed by an appropriate healthcare professional.

It is expected that if I am seeking adjunctive cancer support, I am under the care of an oncologist.

**Alternative care**

**I understand that there are treatment options available for my condition other than acupuncture** a**nd that I have the right to a second opinion** and to secure other options about my circumstances and healthcare as I see fit.

**Informing the practitioner**

I understand that **I must inform and continue to fully inform my practitioner of any medical history, family history, medications, and/or supplements being taken currently (prescription and over the counter).**

**Pregnancy**

I understand that some treatments may be inappropriate during pregnancy, and **I will notify my practitioner if I am, or become, pregnant or if I am nursing**.

**Outcomes**

I understand that, as with all healthcare approaches, **results are not guaranteed**, and **there is no promise to cure.**

**Data protection**

I understand the practitioner may review my patient records and lab reports, but all my records will be kept confidential, will not be released without my written consent.

**Informed Consent**

**I understand that I am the decision maker for my health care.**

**Risks**

**I understand the following list of interventions are within the scope of acupuncture.**

While **I do not expect the practitioner to be able to anticipate and explain all possible risks** **and complications** of treatment, **I wish to rely on the practitioner to exercise** **their** **judgment,** during the course of treatment, which the practitioner thinks at the time, based upon the facts then known, is in my best interest.

**I recognise that these methods are generally safe, but, as with all types of healthcare interventions, there are some risks to care**, including, but not limited to:

Intervention Risk

|  |  |
| --- | --- |
| **Acupuncture and Electro acupuncture** | **Bruising, numbness or tingling** near the needling sites that may last some days.  **Dizziness** or **fainting** may occur during or after needle insertion.  Unusual risks of acupuncture include **nerve damage** and **organ puncture**, including lung puncture (pneumothorax).  **Infection** is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. |
| **Moxibustion and TDP Heat lamps** | **Burns** and/or **scarring** are a potential risk of moxibustion and heat lamps. |
| **Guasha and Cupping** | **Bruising** is a common side-effect and these may last up to 14 days or more. |
| **Tui-Na** (Chinese massage) | None |
| **Nutritional counselling** | None |
| **Prick bleed with a lancet** | **Bruising, soreness, emotional release, infection.** |
| **Auricular acupuncture** | **Infection** |
| **Ear seeds** | **Soreness, allergy** |
| **Plum Blossom Needle** | **Bruising, soreness** |

**Consent**

By voluntarily signing below, **I confirm that I have read, or have had read to me all 3 pages of this document, have been told about and fully understand the risks and complications of acupuncture and other procedures and have been fully informed.**

**I have had an opportunity to ask questions or decline treatments**

**I have been given the appropriate aftercare advise sheets**

**I hereby request and consent freely to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Katherine Dukes.**

**I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.**

**I also consent to my details and records to be held for a period of seven years from the treatment date in accordance with the Data Protection Act.**

PATIENT NAME:

ACUPUNCTURIST NAME:

Katherine Dukes

PATIENT SIGNATURE (Or Patient Representative)

DATE

PATIENT REPRESENTATIVE RELATIONSHIP: