Consent and Authorization for Intravenous Therapy Procedures

Client's Name:_____ Date:_____

Vitamins are vital for our body's normal function and are absolutely necessary for our growth, general well-being, and vitality. Except for a few exceptions, vitamins cannot be manufactured or synthesized by the body and their absence or improper absorption results in specific deficiency diseases. Therefore it is important for our body to obtain vitamins from outside sources to battle against the chance for a deficiency. Latest researchers indicate that many vitamins take in large doses can have miraculous healing effects in a wide range of common complaints and illnesses. Proper vitamin injections can supply the much-needed nutrients your body needs to maintain and enhance normal bodily function.

Vitamin Injections are better absorbed by the body since they go directly into the bloodstream. Alternatives to these injections are Oral Vitamin, Capsules, Liquid drinks, Lotions, Topical Creams, and Mouth Sprays.

Vitamin Injections common side effects include but are not limited to:
1. Risks: I understand there is risk of *mild diarrhea, upset stomach, Nausea, a feeling of pain and a warm sensation at the site of the injection, a feeling, or a sense, of being swollen over the entire body, headache and joint pain.*

2. If any of these side effects becomes severe or troublesome I will contact my physician immediately.

3.I understand that although rare Vitamin Injections can result in serious side effects. Although this is a relatively rare occurrence, anyone taking Vitamin Injections should be aware of the possibility. Uncommon side effects are much more serious than common side effects of Vitamin Injections, and such side effects should be reported to a physician to be evaluated for seriousness. Uncommon and dangerous side effects include:
-Headache -Nausea -Diarrhea -Bloating -Constipation -Indigestion or Heartburn -Abnormal bleeding -Gastrointestinal hyperactivity -Chest pain -Flushed face -Chills -Fever -Upset stomach -Kidney Stones -Fingernail weakening -Hairloss -Rapid heartbeat -Heart palpitations -Restlessness -Muscle cramps and weakness -Dizziness

4. I understand the possibility of having an allergic reaction to any of the ingredients found within the Vitamin Injection is quite plausible and that I should communicate with my physician if I have any known allergic reactions to food, dyes, preservatives, or any other substances. If I experience any of these following signs of allergic reaction I should immediately consult my primary health care physician and discontinue further use of the product. Signs of allergic reactions include, but are not limited to:- *Itching of skin -Hives -Rashes -Wheezing -Difficulty breathing -Swelling of the mouth or throat.*

5. When medications are taken in conjunction with the Vitamin Injections, drug interactions could occur. These interactions can either increase your risk of bleeding or block the absorption of the vitamins into the body. These medications at the time of your injection should either be discontinued or be consulted with/

or by a physician. Some of the medications that may cause drug interactions include, but are not limited to:

-Heparin (Fragmin, Lovenox, Innohep…..etc.) -Antithrombin (A Tryn, Thrombate III) -Argatroban -Aspirin -Ibuprofen -Dipyridamole (Persantine) -Bivalirudin (Angiomax) -Clopidogrel (Plavix) -Warfarin (Coumadin, Jantoven) - Nonsteroidal anti-inflammatory drugs (Ibuprofen, etc.)

6. Before starting the Vitamin Injections I will make sure to tell my physician I am pregnant, lactating or have any of the following conditions.

-Leber's disease - Kidney disease -History of kidney stones -Liver disease -Hormonal disease -Cardiovascular disease -History of ulcers -History of gastrointestinal problems -Bipolar disorder (maniac depression) -Attention deficit hyperactivity disorder (ADHD) -Muscular dystrophy -Elliptic seizures -Hypoglycemia -Schizophrenia -Benign prostate hypertrophy (BPH) -Acetaminophen poisoning -Hypertension (high blood pressure) -History of seizures -Underactive thyroid (hypothyroidism) -Osteoporosis -Receiving treatment or taking any medications that might "thin" the blood -Receiving treatment or taking medications that has an effect on bone marrow -An infection -Iron deficiency -Folic acid deficiency -Dependent on intravenous nutrition or liquid nutrition products for food -Diabetes, MellItus or High blood sugar levels -An unusual or allergic reaction other medicine since foods, dyes, or preservatives.

7. I understand that certain herbal products, vitamins, minerals, nutritional supplements, prescriptions and non-prescription medications may result in side effects when they interact with the Vitamin Injections.

8.Treatments: Will be determined by the provider. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of a non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees, should this be required. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risk. I hereby give consent to perform this and all subsequent Vitamin Injections with the above understood. I hereby release the doctor, the person injecting the Vitamin Injection, and the facility from liability associated with this procedure.

Print Name:_____ Nurse/EMT Print Name:_____

Contact No:_____ Date:_____Time:_____

Email:_____ Nurse/EMT Signature :_____

Patient Signature:_____

Pre and Post Vitals Form

OFFICIAL USE ONLY

Patient name: **DOB:** **COCKTAIL TYPE:**

New Patient :	Yes No	How did you hear about us:	
Date/Time:		Home Visit?	YES NO
DOB:		Location:	
Height:		Paying with Flex?	
Weight:		Paying with HSA?	

Estimated Time:		**Pre Vitals**	**Post Vitals**
Drip Rate:		**BP**:	**BP**:
Start Time:		**TEMP**:	**TEMP**:
End Time:		**02**:	**02:**
Insertion Site:		**HR**:	**HR**:

Reason for Visit:	**EXPIRE DATE CHECK**: YES NO **Patient Instructions Pre IV**:
Exam: Skin Intact: YES NO	Type of Needle: Protect IV: Gauge of Needle: 20G 22G 24G
Blood return on insertion: YES NO	Number of Attempts:
Assessment of insertion site: Clean / Dry / Intact: YES NO Swelling/ Redness: YES NO COCKTAIL TYPE:	Patient instructions Post IV: IV catheter intact upon removal: YES NO
Follow up plan:	Notes:
NURSE SIGNATURE: DATE:	Tips: Discount: NO YES **TOTAL:**

Confidential Medical Profile

Patient info:

First Name:_____ Last Name:_____

Date of Birth: _____/_____/_____

Phone Number:_____E-mail:_____

Address:_____

Emergency Contact Info:

Emergency Contact #1:

First Name:_____Last Name:_____

Phone Number:_____ Relationship:_____

Emergency Contact #2:

First Name:_____Last Name:_____

Phone Number:_____ Relationship:_____

To avoid unforeseen complications, it is very important that you answer the following questions honestly and to the best of your knowledge.

Do you have or previously had any of the following: (Check mark YES or NO and explain where necessary.

YES NO 18 Years of age or older
YES NO History of MRSA (methicillin-resistant Staphylococcus aureus)
YES NO Botox (Last Treatment_____)
YES NO Diabetes- [Type 1 OR Type 2]
YES NO Hepatitis - A C B D
YES NO HIV Positive
YES NO Forehead/ Brow Lift/ Facelift/ Nova string
YES NO Easy Bleeding
YES NO Alcoholism
YES NO Abnormal Heart Condition (Explain:_____)
YES NO Taking medications including immunosuppressive, such as anti-inflammatory or steroids.
YES NO Chemical or Laser Peel (Last Treatment_____)
YES NO Are you pregnant or nursing?
YES NO Brow Lash Tinting (Last Treatment_____)
YES NO Cancer (Type:_____ Year_____)

YES **NO** Are you currently or have you ever undergone Chemotherapy/ Radiation
(How long in Remission _____)
YES **NO** Tumors/Growths/Cysts
YES **NO** History of skin diseases or remarkable skin conditions or sensitivities?
YES **NO** Oily Skin
YES **NO** Currently taking Accutane or acne treatment (Type:_____)
YES **NO** Currently taking Vitamin A or Vitamin E in any form?
(Explain:_____)
YES **NO** Tan by booth or salon
YES **NO** Taking blood thinner such as: Aspirin, Ibuprofen, Alcohol, Coumadin, etc.
(currently or within the last 7 days)
YES **NO** Allergic reaction to any medications such as Lidocaine, Tetracaine, Epinephrine, Dermacaine, Benzyl Alcohol, Adverse reaction to dentist treatment, Carbopol, Lecithin,Propylene Glycol, Vitamin E Acetate, other:_____
YES **NO** Allergies to metals, latex, food, topical anesthetic, other:_____
YES **NO** Do you use skincare products containing Retin-A, Glycol Acid, or Alpha Hydroxyl?
YES **NO** Are you currently under the care of a physician? (Explain:_____)
YES **NO** Have you taken any mood altering drugs in the last 8 hours? (Explain:_____)
YES **NO** Do you have problems with healing? (Explain:_____)
YES **NO** Any diseases or disorders not listed:_____

Circle all that apply:

Heart conditions, Allergies to make up, Keloid or Scars, Stroke, Chest pain, Shortness of breath, Alopecia, Epilepsy,Seizures, Refractive eye surgery, Glaucoma, Trichotillomania, Hepatitis, HIV, Jaundice, Kidney disease, Darkening of skin, Rosacea, Eczema.

Please list any medications you are currently taking including (natural supplements):_____
_____

Are there any other medical conditions that we should be aware

of:_____

I agree that all the above information is true and accurate to the best of my knowledge and accept that it is my responsibility to consult with my physician and obtain the appropriate doctors notes for any contradiction that I believe may exist prior to undergoing this procedure

Signature:_____ Date:_____