Treatment Consent Form

I, _____, understand that fully trained RNs and APRNs will be performing the IV therapies. I acknowledge that I was informed and I understand the benefits, risks, and alternatives of the treatment(s) elected. I recognize that the treatment can pose risks of side effects, reactions, and more serious complications. I understand that some of the risks of the treatment may be serious or even life threatening. It has been explained to me that each client reacts differently to treatment and that I may experience none, some, or all of the problems described above. Further, I understand that there is the possibility of unexpected or previously unknown side effects, reactions, or other complications. I understand that the treatment team will take precautions to prevent and/or minimize risks, but that despite precautions that may be taken, complications may still occur. _____ **Client Initials**

I was informed, and I understand, that no promise or guarantee is made to me concerning the treatment, including any promise or guarantee of effectiveness or of a certain outcome.

_____ **Client Initials**

I have read this consent form (or have had it read to me) and I understand it. I have discussed the content of this consent form with the treatment provider and have had all of my questions answered. I acknowledge that I have been given sufficient information to make an informed decision about consenting to the infusion(s) elected. _____ **Client Initials**

By signing below, I consent to the treatment, and that this consent is revocable at any time by me, except to the extent it has already been relied upon.

_____ _____

Client Printed Name Date

_____ _____

Client Signature Provider Signature