DALY INTEGRATED
MEDICAL GROUP

INTRAVENOUS AND INTRAMUSCULAR NUTRIENT INJECTION CONSENT FORM

Patient Information

Last Name	First Name			Today's Date
Home Address	City		State	Zip
Home Phone	Work Phone	Cell Phone	Email Address	
Permission to Leave Messages ☐ YES ☐ NO	Gender	Date of Birth	Age	Marital Status ☐ S ☐ M ☐ D ☐ Sep
Occupation	Employer			
Emergency Medical Contact	Phone	Relationship to Patient		
Primary Physician Name	Phone	How did you hear about us?		

MOST IMPORTANT HEALTH CONCERNS, STARTING WITH THE MOST IMMEDIATE

1.	4.
2.	5.
3.	6.

USUAL HEALTH: ☐ **EXCELLENT** ☐ **GOOD** ☐ **FAIR** ☐ **POOR** **HEIGHT:** _____ **WEIGHT:** _____ **BP:** _____

Do you use any of the following **MEDICATIONS** used more than just occasionally? (**YES** or **NO**)

	Pain Relievers		Birth Control *(pills, patch, implant, IUD)*		Steroids *(inhalers, creams, oral)*		Blood Thinners *(coumadin, warfarin, heparin)*
	Tranquilizers		Thyroid Medication		Nasal Decongestants		Diuretics
	Benzodiazepines		Hormones		Antacids		Appetite Suppressants
	Sleeping Pills		Stimulants		Laxatives		

List any prescription or over-the-counter **MEDICATIONS** and **SUPPLEMENTS** you take regularly.

Name	Dose	Reason	Start Date	Side Effects

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

_____ **INITIAL HERE TO CONFIRM**

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IV Therapy Consent Form

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by the physician at **Daly Integrated Medical Group.**

I have informed the physician of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the doctor of all current medications and supplements.

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 had an opportunity to receive such information and to give my informed consent.

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.
    b. Rarely:
        i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    c. Extremely Rarely:
        i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest, and death.
4. Benefits of intravenous therapy include:
    a. Injectables are not affected by stomach, or intestinal absorption problems.
    b. Total amount of infusion is available to the tissues.
    c. Nutrients are forced into cells by means of a high concentration gradient.
    d. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseeable complications could occur. I do not expect the physician(s) to anticipate and or explain all risk and possible complications. I rely on the physician(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 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 therapy with any different or further procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

Chelation Therapy" is a term used in conjunction with IV nutrient therapy. If you are receiving IV therapy for detoxification, and – or the treatment of heavy metals in your body then your therapy may include a chelating substance, such as EDTA or DMPS along with specific nutrients. Any use of chelation outside of those boundaries is outside of those boundaries is outside the scope of Florida State Law and will not be offered in this clinic.

My signature below confirms that:

1. I understand the information provided on this form and agree to the foregoing.
2. The procedure(s) set forth above has been adequately explained to me by my physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of the procedure(s).

_____	_____	_____
Patient's Name	*Patient's Signature*	*Date*
Candice Vaknin, APRN		
Physician's Name	*Physician's Signature*	*Date*