

INTRAVENOUS THERAPY INFORMED CONSENT

1. You have the right to be informed of the intravenous procedure, any feasible alternative options, and the risks and benefits of the treatment.
 - a) The IV procedure involves inserting a needle into your vein or muscle and injecting the formula described by your naturopathic doctor.
 - b) Alternatives to IV therapy include oral supplementation and/or dietary and lifestyle changes.
 - c) Risks of IV therapy may include:
 - i) Discomfort, bruising, and pain at the injection site
 - ii) Inflammation of the vein used for injection (phlebitis)
 - iii) Allergic reactions and in rare cases, severe anaphylaxis
 - d) Benefits of IV therapy include:
 - i) Injectables are not affected by stomach or intestinal disease
 - ii) Total amount of infusion is available to the tissues
 - iii) Nutrients are forced into the cells by means of high concentration gradient
 - iv) Higher doses of nutrients can be given than is possible by mouth without causing intestinal irritation
2. You have the right to consent to or refuse the proposed treatment at any time during the procedure. Your signature on this form affirms that you have given your consent to the procedure(s) described above with any different or further procedures, which, in the opinion of your naturopathic doctor, may be indicated.
3. The procedure will always be performed by or under the direction of a naturopathic doctor.

Your signature below indicates the following:

- a) You understand and acknowledge the information and risks explained on this form and agree to the proposed treatment.
- b) The procedure(s) set forth has been adequately explained to you by your naturopathic doctor
- c) You have received all the information and explanation you desire concerning the procedure
- d) You understand and acknowledge the cancellation policy for IV treatments

PLEASE NOTE that IV solutions need to be prepared the same day of the treatment. If you must cancel your appointment for any reason, you must do so at least **3 hours before** your scheduled appointment time otherwise the IV bag/fluid in syringe will have to be discarded and you will be responsible for the cost of the treatment.

Patient Name: (Please print name): _____

Signature of Patient or Guardian: _____ Date: _____

Witness: _____