



Rockwall Rapid Care  
2313 Ridge Road, Suite 102  
Rockwall, TX 75087  
Office: (469) 769-5688 Fax: (469) 698-8686

## IV Infusion Consent

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by the provider at **Rockwall Rapid Care**

(Initials) \_\_\_\_\_ I have informed the provider of any known allergies to drugs or other substances, or of any past reactions to anesthetics.

(Initials) \_\_\_\_\_ I have informed the provider of all current medications and supplements.

(Initials) \_\_\_\_\_ I have informed the provider of all known chronic health conditions including **Diabetes Mellitus, Kidney Disease Cardiac Arrhythmia or G6PD Deficiency.**

### Side Effects/Risks

(Initials) \_\_\_\_\_ 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.
    - ii. General feeling of warmth during and after injection
  - b. Rarely:
    - i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    - ii. Reactive Hypotension (or rapid drop in blood pressure)
    - iii. Reactive Hypoglycemia (or rapid drop in blood sugar)
  - c. Extremely Rarely: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

### Benefits of intravenous therapy include:

1. Injectables are not affected by stomach, or intestinal absorption problems.
2. Total amount of infusion is available to the tissues.
3. Nutrients are forced into cells by means of a high concentration gradient.
4. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.



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### The Procedure

The IV intravenous procedure involves inserting a needle into your vein and infusing over a determined period of time, prescribed nutrients (vitamins, minerals, amino acids) or chelation agents.

Your vitals will be measured prior to and after your infusion. **What Safety Precautions Must You Take?**

- Monitor the insertion site for signs and symptoms of infection (redness, swelling, discharge). Notify the clinic immediately. If you experience a sustained fever greater than 101, do not delay treatment and go to the ER as this can be a sign of sepsis.
- If you experience a minor side effect while you are at home, you should contact our office, otherwise contact your medical provider or call 911.

### My Consent for Nutrient Infusion Therapy is Voluntary

(Initials) \_\_\_\_\_ My request for nutrient infusion therapy as described is entirely voluntary and I have not been offered any inducement to consent. I understand that I may refuse treatments at any time.

### Statement of Person Giving Informed Consent

I have read this consent form and understand the information contained in it. I understand the risks and benefits and have had the opportunity to have all my questions answered to my satisfaction. I am aware that other unforeseeable complications could occur. I do not expect the provider(s) to anticipate and or explain all risk and possible complications. I rely on the provider(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 of 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 give my consent to IV nutrient therapy.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

### RELEASE OF MEDICAL INFORMATION

I hereby authorize **Rockwall Rapid Care** to disclose my medical records, to EMS, my spouse, and emergency contact. I also authorize **Rockwall Rapid Care** to discuss my care and share my medical information for the purposes of monitoring, quality control or safety concerns.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date