City Infusions
Your Relief Starts Here

Intravenous (IV) Therapy Consent Form

(Initials) _____ I have informed the nurse and/or physician of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

(Initials) _____ 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.

(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: Discomfort, bruising and pain at the site of injection.
   b. Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
   c. Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

(Initials) _____ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) and/or physician(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or 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 of my questions answered.

(Initials) _____ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance.

My signature below confirms that:

1. I understand the information provided on this form and agree to the all statements made above.
2. Intravenous (IV) Therapy has been adequately explained to me by my nurse and prescribing physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Therapy.

Patient's Printed Name and Date of Birth

_____

Patient's Signature and Date

_____

Registered Nurse's Printed Name

_____

Registered Nurse's Signature and Date

_____