Intravenous (IV) Infusion Therapy Consent Form 103

Care of Oncology Patients

I, the undersigned, have been given informed consent for the procedure of Intravenous (IV) Infusion Therapy as ordered by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I (patient) have informed the nurse and / or physician of any known allergies to medications or other substances. \_\_\_\_\_(initial) I have informed the nurse and / or physician of all current medications and supplements.\_\_\_\_\_(initial) I have fully informed the nurse and /or physician of my medical/ surgical history.\_\_\_\_\_\_(initial) I understand IV infusions therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician’s medical care. \_\_\_\_\_\_\_(initial)

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 an opportunity to receive such information and to give my informed consent. \_\_\_\_\_\_\_(initial)

I understand my current treatment regimen prescribed by Oncology supersedes any adjunctive therapy offered. IV Infusion therapy will be used only as such. I have discussed IV infusion, vitamin therapy and this had been approved by my Oncologist as an adjunctive therapy. I further agree to follow up with my care team as instructed and agree IV infusion is NOT a primary treatment modality.

I (patient) understand:

1. The procedure involves inserting a needle into the vein and injecting the solution.

2. Alternatives to IV therapy are oral supplements, intramuscular supplements, or dietary and lifestyle changes

3. Risks of IV therapy include but are not limited to: a) Occasionally: discomfort, bruising and pain at the site of injection, local bruising, or hematoma b) Rarely: inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrhythmias, and death.

4. Benefits if IV therapy include: a) Injectables are not affected by stomach, or intestinal absorption problems b) Total amount of infusion is available to the tissue. c) Nutrients are forced into cells by means of high concentration gradient. d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseen 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 judgement during treatment to 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 infusion therapy, including any other procedure which, in the opinion of my physician(s) or other associated with this practice, may be indicated. My signature below confirms that:

1. I understand the information provided on this form and agree with all statements made above.

2. Intravenous Infusion Therapy has been adequately explained to me by my nurse and / or physician.

3. I have received all the information and explanation I desire concerning the procedure.

4. I authorize and consent to the performance of IV insertion and Intravenous (IV) Infusion Therapy and/or Medication injection.

5. I release Nicole Lundy, CRNP, Integrative Health & Wellness PLLC and My Wellness Drip and all the medical staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.

Patient Name (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our mutual patient is requesting the following services that require the approval of the Oncologist responsible for the above listed patient’s care plan. By signing this form, you acknowledge you have physically seen and evaluated this patient within the last 90 days and he/she is under your care.

Oncology Physician/ CRNP/ PA (Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oncology Physician/ CRNP/ PA (signature)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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