# IV Nutritional Therapy for Physicians

## Consent and Authorization for

***INTRAVENOUS THERAPY PROCEDURES***

---

To:

Procedure: Multi vitamin Cocktail

Physician performing procedure: Dr. Heather Friedman

1. Dr. Heather Friedman provides facilities and personnel to assist your physician in the performance of intravenous therapy. You 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 you have had an opportunity to receive such information and to give your informed consent.
    a. The procedure involves inserting a needle into your vein or muscle and injecting the formula described above by your physician.
    b. Alternatives to intravenous therapy is oral supplementation and/or dietary and lifestyle changes.
    c. Risks of intravenous therapy include:
        i. Discomfort, bruising and pain at the site of injection.
        ii. Inflammation of the vein used for injection, phlebitis.
        iii. Severe allergic reaction, anaphylaxis, cardiac arrest and death.
    d. Benefits of intravenous 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 cells by means of a high concentration gradient.
        iv. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.
2. You have the right to consent to or refuse and proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent ot the procedure(s) described above with any different or further procedures which, in the opinion of your physician, may be indicated.
3. The procedure will be performed by or under the direction of the physician named above with qualified medical assistants.

Your signature below means that:

a. You understand the information provided on this form and agree to the foregoing.
b. The procedure(s) set forth above has been adequately explained to you by your physician.
c. You have received all the information and explanation you desire concerning the procedure.
d. You authorize and consent to the performance of the procedure(s).

DATE: _____ TIME: _____

SIGNATURE: _____

Patient/Representative

If signed by representative, indicate relationship: _____ Date: _____

WITNESS : _____

## IV Nutritional Therapy for Physicians

**IV THERAPY INTAKE FORM**
**TO BE COMPLETED BY PHYSICIAN**

Patient: _____Date: _____
Referring Doctor: _____Age: _____ Sex: _____
Reason for referral including ICD-9 code: _____
_____
Prescription: _____
Frequency: _____
Current health concerns: _____
_____
Current medications: _____
Date of last chemistry screen: _____
Past Medical History – Has the patient ever been diagnosed with:
Hypertension _____ Angina _____ Ankle swelling _____
Arrhythmia _____ CHF _____ MI _____
Abnormal EKG _____ Kidney dz. _____ Gen. Edema _____
Bleeding disorder _____ Asthma _____ Pulmonary edema _____
Sudden wt. Loss _____ DM _____ Anxiety or panic attack ____
Is patient pregnant? _____ G6PD Deficiency _____
Allergic reactions (specific)_____
Pertinent details of conditions checked above: _____
_____
_____

**Referring Dr. Signature: _____**

To Be Filled Out By IV Team

Date of 1st Intake: _____
Known allergens: _____
Allergy to Latex?: _____ Shellfish _____ Iodine _____
When indicated:
Presence of edema: _____ Lung sounds: _____
Heart sounds: _____
Vital Signs:
BP: _____ Pulse: _____ Resp: _____ Temp: _____
Weight _____

Progress Notes: _____
_____
_____
_____
_____