



Nutrient Infusion Informed 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 Magnolia Med Spa and Wellness Center

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

(Initials) _____ I have informed the doctor of all current medications and supplements.

(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.

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.

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 the _____, 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 _____ to disclose my medical records, to Magnolia Med Spa and Wellness Center, EMS, my spouse, and emergency contact. I also authorize Magnolia Med Spa and Wellness Center staff to discuss my care and share my medical information for the purposes of continuity of care, monitoring, emergency care, quality control or safety concerns.

Signature of Patient _____

Date: _____

