IV/IM NUTRITION

Consent and Authorization for Intravenous Therapy Procedures

Patient Name: _____

Procedure: _____

Medical Provider performing procedure: _____

1. This practice provides facilities and personnel to assist your Medical Provider in the performance of intravenous and/or intramuscular 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 Medical Provider.
    b. Alternatives to intravenous therapy are 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 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 any proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedure(s) described above with any different or further procedures which, in the opinion of your Medical Provider, may be indicated.
3. The procedure will be performed by or under the direction of the Medical Provider named above with qualified medical assistants or registered nurses.

Your signature below means that:

1. You understand the information provided on this form and agree to the foregoing.
2. The procedure(s) set forth above has been adequately explained to you by your Medical Provider.
3. You have received all the information and explanation you desire concerning the procedure.
4. You authorize and consent to the performance of the procedure(s).

Signature: _____ Date: _____

If signed by representative, indicate relationship: _____

Witness: _____ Date: _____

Living Well Balanced
Integrative Medical Centers

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