# IV Therapy Informed Consent Form and Medical History

DOCTOR wellness

## Personal Information

Surname: _____ Forename: _____

Address : _____

Post Code: _____ Ethnicity: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Mobile: _____ Home: _____

Email address: _____

Occupation: _____

GP's Name: _____

GP's Address: _____

By completing this questionnaire , you will assist us in evaluating you and your specific concerns. The information you provided will be used to determine what factors may be affecting you so that we may recommend the proper treatment care.

## Choice of IV/IM Vitamins

## Vitals

Tempreture: _____ Blood Pressure: _____ Pulse: _____

## Lifestyle

How many hours do you sleep at night? _____

How often do you exercise? _____

On a scale from 1 (low) to 10 (high), how would you rate your stress levels? _____

## Nutrition

Please indicate the frequency of these foods consumed on a weekly basis:

Sugar: _____ Snack Foods: _____

Spicy Foods: _____ Fast Food: _____

Salty Foods: _____

Please indicate the quantities of fluid consumed daily:

Water: _____ Coffee: _____ Juices: _____

Tea: _____ Fizzy Drinks: _____

Allergies:

Type of reaction:

Please list all medications that you have been prescribed by your GP:

Please list any non-prescriptive/ Over the counter medicine or any recreation drugs:

Have you had recent surgery or due to undergo surgery? ☐ Yes ☐ No

If yes, when? _____

Where on your body? _____

What information can you provide about the procedure?

1.Have you been hospitalized or under the care of a physician in the past month? ☐ Yes ☐ No

2.Do you currently take any blood thinners? ☐ Yes ☐ No

3.Do you currently take or use any type of steriods? ☐ Yes ☐ No

4.Are you pregnant? ☐ Yes ☐ No

5.Are you breast feeding? ☐ Yes ☐ No

If you answered ‘Yes’ to any of the above questions 1-5, you may be advised by your practitioner that you cannot receive any IV fluids and you may be denied services. I understand that participating in the intravenous (IV) hydration and vitamin administration services provided by Doctor Wellness and Partners carries risks.

I have truthfully answered all questions regarding my medical history and have informed the practitioner about any and all prescription medications and/or over the counter drugs I take, as well as any street or recreational drugs. I understand that failing to inform the practitioner about my medical issues and/or drug use can lead to serious complications.

I acknowledge that I am responsible for any medical care I may have that is directly or indirectly related to the services provided by Doctor Wellness and Partners. If I seek medical treatment for any side effects or reaction, it will be at my own expense.

I acknowledge and agree that the sole risk of injury or harm resulting in any manner from my voluntary participation in Doctor Wellness IV services rests entirely with me if I fail to disclose any of my health condition(s), medications, or drug use in advance of the services provided. I expressly represent and warrant to Doctor Wellness and Partners that I have never been diagnosed with or treated for any illnesses or conditions that may result in increased risk when participating in the services provided by Doctor Wellness and Partners. I understand that Doctor Wellness and Partners bear no responsibility for and will not screen for, diagnose, monitor, or provide any care for such conditions. I acknowledge that Doctor Wellness and Partners relies upon information provided by me in assessing my suitability to participate in the services provided.

**Please check any health conditions which you have previously or currently experiencing:**

| | | | |
|---|---|---|---|
| ☐ Allergies | ☐ Diabetes | ☐ Hormonal Disorders | ☐ Immunosuppression |
| ☐ Arthritis | ☐ Transplant | ☐ Keloid Scarring | ☐ Recent operation |
| ☐ Cancer | ☐ Liver Disease | ☐ Hypoglycaemia | ☐ Thrombosis or Phlebitis |
| ☐ Smoking | ☐ Recent Illness | ☐ Varicose Veins | ☐ Viral or Bacterial Infection |
| ☐ Pregnancy | ☐ Claustrophobia | ☐ Asthma / COPD | ☐ Gastrointestinal bleeding |
| ☐ Alcoholism | ☐ Heart Conditions | ☐ Breast Feeding | ☐ Anticoagulant Medication |
| ☐ Epilepsy | ☐ Kidney Disorders | ☐ Systemic Diseases | ☐ Auto Immune Condition |
| ☐ Pacemaker | ☐ Muscular Condition | ☐ Previous Surgery | ☐ Congestive Heart Failure |
| ☐ Hysterectomy | ☐ Multiple Sclerosis | ☐ Water Retention | ☐ High/Low Blood Pressure |
| ☐ Kidney Disease | ☐ Renal Insufficiency | ☐ Thyroid Disorders | ☐ Lack of Normal Skin Sensations |
| ☐ None | | | |

There is no guarantee that hydration therapy will temporarily or permanently cure or resolve your hangover, effects of altitude sickness, dehydration, or viral illness. Please drink alcohol in moderation. Heavy drinking after hydration therapy can lead to stomach irritation or other complications. Hydration therapy is not a cure for heavy drinking. Excessive drinking can lead to alcohol poisoning and other serious medical problems. Always drink alcohol in moderation.

I acknowledge that I have been given the opportunity to discuss the nature and purpose of the treatment and the risks, complications, and consequences associated with the procedures. I am aware that it is impossible to foresee or predict all possible risks, complications, and consequences, and I do not expect that the practitioner to anticipate or explain all associated risks. I waive any and all claims related to the services provided and agree to hold Doctor Wellness and Partners harmless regarding any complications or consequences I experience during or following the service.

This document is intended to serve as confirmation of informed consent for IV therapy as ordered by the practitioner. I have informed the practitioner of any known allergies to drugs or other substances, or of any past reactions to anaesthetics. I have informed the practitioner of all current medications and supplements.

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. 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: 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 Rarely: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

4. Benefits of intravenous therapy include:

A. Injectables are delivered directly into the bloodstream, and therefore do not affect the stomach, or intestinal absorption.
B. Full dose is absorbed by infusion. Nutrients are absorbed into cells by means of a high concentration gradient. Although higher doses of nutrients have been given orally without intestinal irritation, absorption rate remains low and is limited by intestinal absorption.

I am aware that other unforeseeable complications could occur. I do not expect the practitioner to anticipate and/ or explain all risk and possible complications. I rely on the practitioner to exercise judgment during 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 or refuse any proposed treatment at any time prior to its performance.

## IV VITAMIN HYDRATION RISKS INCLUDE THE FOLLOWING:

My signature on this form affirms that I have given my consent to IV therapy with any different or further procedures which, in the opinion of my practitioner or others associated with this practice, may be indicated. My signature below constitutes my acknowledgement that

1. I have read, understood and fully agree to the foregoing and I have received and read the pre and post care treatment information document.
2. I give consent to the proposed treatment process that has been satisfactorily explained to me and I have all the information that I desire.
3. I hereby give my consent and authorisation voluntarily and release Doctor Wellness and Partners of any claims that I have or may have in the future in connection with the described treatment.

## GDPR & DATA PROTECTION:

I understand that my information will be kept strictly confidential and will not be shared with anyone but with Doctor Wellness and Partners. By signing below I am agreeing to information being shared with Doctor Wellness and Partners.

My signature on this form affirms that I have given my consent to IV therapy with any different or further procedures which, in the opinion of my physician(s) or other associated with this practice, may be indicated.

My signature below constitutes my acknowledgement that:

(1) I have read, understood and fully agree to the foregoing and I have received and read the pre and post care treatment information document.

(2) Give consent to the proposed treatment process that has been satisfactorily explained to me and I have all the information that I desire.

(3) I hereby give my consent and authorisation voluntarily and release the establishment and its agents of any claims that I have or may have in the future in connection with the described treatment.

Clients full name:

Client signature:

Date:

Therapist Full Name:

Therapist signature:

Date: