

## CONSENT FORM FOR IV VITAMIN THERAPY

### CONSENT FORM FOR IV VITAMIN THERAPY

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

#### Medical History Questionnaire:

1. Do you have any known allergies? (e.g., medications, foods, latex)

- Yes \_\_\_ No \_\_\_

- If yes, please list: \_\_\_\_\_

2. Are you currently taking any medications or supplements?

- Yes \_\_\_ No \_\_\_

- If yes, please list: \_\_\_\_\_

3. Do you have any chronic medical conditions? (e.g., diabetes, heart disease, kidney disease)

- Yes \_\_\_ No \_\_\_

- If yes, please list: \_\_\_\_\_

4. Have you had any recent surgeries or medical procedures?

- Yes \_\_\_ No \_\_\_

- If yes, please specify: \_\_\_\_\_

## CONSENT FORM FOR IV VITAMIN THERAPY

5. Do you have a history of intravenous (IV) therapy complications?

- Yes \_\_\_ No \_\_\_

- If yes, please describe: \_\_\_\_\_

6. Are you pregnant or breastfeeding?

- Yes \_\_\_ No \_\_\_

7. Do you have a history of fainting or dizziness?

- Yes \_\_\_ No \_\_\_

8. Do you smoke or use recreational drugs?

- Yes \_\_\_ No \_\_\_

- If yes, please specify: \_\_\_\_\_

### **Procedure Information:**

IV vitamin therapy involves the intravenous administration of vitamins, minerals, and other nutrients to support health and well-being. This therapy aims to improve hydration, boost energy levels, enhance the immune system, and promote overall wellness.

### **Procedure Description:**

- The procedure typically takes 30-60 minutes.

- A healthcare provider will insert an IV catheter into a vein, usually in the arm, to administer the vitamin solution.

- You may feel a slight pinch during the insertion of the needle.

- You will be monitored throughout the procedure to ensure your comfort and safety.

## CONSENT FORM FOR IV VITAMIN THERAPY

### **Potential Risks and Side Effects:**

While IV vitamin therapy is generally safe, potential risks and side effects include:

- Pain, bruising, or swelling at the injection site
- Infection at the injection site
- Allergic reactions
- Dizziness or fainting
- Electrolyte imbalances
- Fluid overload

### **Before the Procedure:**

- Inform your healthcare provider of any medical conditions, medications, or allergies.
- Hydrate well before the procedure.
- Avoid alcohol and caffeine on the day of the treatment.

### **After the Procedure:**

- Continue to hydrate well.
- Monitor the injection site for any signs of infection (redness, swelling, warmth).
- Follow any additional instructions provided by your healthcare provider.

## CONSENT FORM FOR IV VITAMIN THERAPY

### Consent:

I have read and understand the above information about IV vitamin therapy. I have discussed the procedure with my healthcare provider and have had all my questions answered to my satisfaction. I understand the risks and benefits associated with IV vitamin therapy and agree to proceed with the treatment.

By signing this form, I consent to receive IV vitamin therapy from Dr. BB Crook at Arcabee Aesthetics.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_