IV INFUSION FORM

Date: _____

PERSONAL INFORMATION

PATIENT NAME:	DATE OF BIRTH:
ADDRESS:	
PHONE:	EMAIL:

CURRENT MEDICATIONS:

List any medications that you are now taking below. Please include any & all non-prescription (over-the-counter) medications, vitamins, & supplements.

NAME (Medication/Vitamin/Supplement)	DOSE (Please Include Strength/Per Day)	LENGTH (How long have you been taking this?)
1.		
2.		
3.		
4.		

LABS AND ALLERGIES:

Last set of labs:

Please mark any allergies you may have:

Latex		Gluten Allergy	
Shellfish		Dye/Food Preservatives	
Cobalt		Milk Allergy	
Vitamins		Presence of Edema	
Iodine			

Do you have any other allergies or can you think of something you've had an adverse reaction to?

I do not have any known allergies

I have an allergy or adverse reaction to (Please list)

PAST MEDICAL HISTORY:

Have you ever been diagnosed with:

Hypertension		MI (Heart Attack)		Blood/Bleeding Disorder		G6PD	
Angina/Chest Pain		Arrhythmia		Sudden Weight Loss		Leber's Disease	
Swelling		Abnormal EKG		Diabetes		Liver Disease	
CHF		Kidney Disease		Anxiety/Panic Attack		Cancer	

Females - Could you be pregnant? *Yes* *No*

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CONTACT US IMMEDIATELY AT

(614) 219-9983

ADMINISTRATION OF **INTRAVENOUS VITAMINS, MINERALS, AND OTHER NUTRIENTS**

I, _____, DOB _____, hereby authorize the following procedure: **administration of intravenous vitamins, minerals, and other nutrients**.

This procedure is recommended for replacement of these essential nutrients, correction of deficiencies, and for other therapeutic effects, such as improving immune function, improving antioxidant status, reducing oxidative damage, decreasing bronchospasm, improving fatigue, etc. I expressly represent and warrant to The Confidence Lab that I have never been diagnosed with, nor treated for any diseases, illnesses or conditions which may result in increased risk when I participate in regimens, programs or services made available by The Confidence Lab and I am choosing not to participate with any expectation that The Confidence Lab will screen for, diagnose, monitor or otherwise provide any care or treatment for such conditions.

The procedure involves inserting a needle into your vein and injecting the medicine/additives prescribed by your provider. The principal side effects that may accompany intravenous administration of nutrients include:

- **Burning/ stinging, bleeding, infection, swelling and/or scarring at the site of infusion or if IV infiltrates into surrounding tissue**
- **Muscular spasms, weakness, or fatigue, nerve injuries, fluid overload**
- **Light-headedness and/or fainting, allergic reactions (rare)**
- **Local thrombophlebitis, anaphylaxis, cardiac arrest and death (very rare)**

This procedure may be considered medically unnecessary. It may or may not mitigate, alleviate, or cure the condition for which it has been prescribed. This therapy has been recommended to you in the belief that it is of potential benefit in these circumstances and its use will quite probably improve the condition for which you are under treatment and in your overall health.

Based on the risks and potential benefits of the current medically indicated treatment(s) and of this proposed treatment, I have elected to forego or supplement the indicated treatment(s) and receive this proposed treatment from the health professionals at The Confidence Lab as is appropriate and necessary for my care.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the procedure, except as that claim pertains to negligent administration of this procedure. The risks involved and the possibilities of complications have been explained to me. I fully understand and confirm that the nature and purpose of the aforementioned treatment to be provided may be considered unproven by scientific testing and peer-reviewed publications and therefore may be considered medically unnecessary or not currently indicated. I acknowledge no guarantees have been made concerning the results intended from this procedure and that participating in them carries risks. I have been given an opportunity to ask questions, and all of my questions have been answered fully and to my satisfaction.

ADMINISTRATION OF **INTRAVENOUS VITAMINS, MINERALS, AND OTHER NUTRIENTS**

I hereby place myself under your care for intravenous vitamin therapy and agree to the above release. I also verify that all information presented to medical provider in my medical history is true to the best of my knowledge. I am not misrepresenting myself and I place myself under your care for the sole purpose of treatment for these conditions.

I hereby acknowledge that I understand that my insurance coverage, including Medicare/Medicaid, will not cover this service, and that all services ancillary to this treatment may be also non-covered services and non-reimbursable. I agree to be responsible for payment at the time of service for all services, including non-covered services.

AGREED & SIGNED	
PRINT PATIENT NAME:	DATE OF BIRTH:
PATIENT SIGNATURE:	DATE:
WITNESS:	DATE:
MEDICAL PROVIDER:	DATE: