DRAFT FOR REVIEW. NOT FOR PATIENT USE.
Pending review by the practice's attorney and malpractice carrier, and pending the open items listed in the companion summary. Do not print or sign this version.

Sarasota IV Doctors
PHYSICIAN SUPERVISED IV THERAPY

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IV Fluid Therapy: Informed Consent, Acknowledgment of Risks and Authorization

Please read this document in full before signing. Ask us about anything that is not clear.

Patient name	Date of birth	Today's date
Treatment location (address if not our clinic)		**Arrival time**

What this document is. IV therapy is a medical procedure. A catheter is placed into a vein and fluids, vitamins or medications are delivered directly into your bloodstream. Like any medical treatment it carries risks, some of which are serious. This form records that those risks were explained to you, that reasonable alternatives were discussed, and that you agreed to proceed. It does not give up any of your legal rights.

1. Treatment authorized today completed by clinical staff before signing

THIS ENCOUNTER ONLY. DO NOT SIGN A BLANK TABLE.	
Base fluid and volume	
Additives, vitamins, medications and doses	
Infusion rate and estimated duration	
Insertion site	
Supervising physician and Florida license number	
Administered by (name and credential)	

I authorize the supervising physician, and qualified licensed personnel acting under that physician's orders and supervision, to establish peripheral intravenous access, administer the fluids and additives listed above, monitor me during treatment, and discontinue treatment if medically indicated. I understand the physician may decline to administer or may stop IV therapy if my condition, vital signs or symptoms make treatment unsafe or inappropriate.

If an emergency occurs during or immediately after treatment, I authorize the clinician to administer emergency medications and interventions and to activate emergency medical services on my behalf. I understand that ambulance and hospital charges are separate from this practice's fees.

2. Risks of IV insertion

Pain or discomfort
Bruising
Bleeding
Hematoma
Multiple attempts to obtain access
Infiltration of fluid into tissue
Extravasation
Vein irritation or inflammation
Phlebitis
Infection
Cellulitis
Scarring

Nerve irritation or injury
Arterial puncture
Blood clot in the vein (thrombosis)
Air embolism (rare)
Temporary numbness or tingling
Fainting or vasovagal reaction

Although uncommon, these complications may require additional medical treatment or evaluation.

3. Risks of IV fluid administration

Fluid overload
Swelling or edema
Increased blood pressure
Shortness of breath
Pulmonary edema
Worsening heart or kidney conditions
Electrolyte abnormalities
Changes in blood chemistry
Headache
Nausea
Chills
Dizziness
Changes in heart rate
Other treatment specific effects

Heart disease, kidney disease, liver disease, uncontrolled high blood pressure, and disorders affecting fluid or electrolyte balance all increase these risks. Fluid overload can cause significant swelling, breathing difficulty, pulmonary edema, or hospitalization.

4. Additives, vitamins and medications

Anything added to the IV carries risks separate from the fluid itself, including allergic and hypersensitivity reactions, drug interactions, side effects, blood pressure or heart rate changes, electrolyte abnormalities, toxicity, local tissue injury, and reactions that are serious or life threatening.

> **Off-label use.** Many vitamin, mineral and nutrient infusions are not approved by the FDA for the purposes for which they are commonly given, and the FDA has not evaluated their safety or effectiveness for those uses. The reasons for recommending them have been explained to me.
> **Compounded products.** Some additives may be prepared by a compounding pharmacy rather than a conventional manufacturer. Compounded preparations are not FDA approved. I may ask for the name of the compounding pharmacy at any time.

5. Allergic reaction and anaphylaxis

An allergic or hypersensitivity reaction can happen even to something you have tolerated before. Signs include rash, hives, itching, swelling of the face or throat, difficulty breathing, wheezing, dizziness, low blood pressure, loss of consciousness and anaphylaxis. Severe reactions may require emergency treatment and transfer to an emergency facility.

6. Setting of treatment

Treatment today is being provided (check one):

☐ At the clinic address shown at the top of this form

☐ **At a home, hotel, office, boat or other non-clinical location.** If this box is checked, I understand that a non-clinical location may not have the emergency equipment, medications, monitoring or trained personnel available in a hospital or emergency department; that sterile conditions differ from a licensed facility; and that emergency medical services may take longer to reach me. I accept these additional risks.

7. Infection

Placing an IV breaks the skin and therefore carries a risk of infection. Aseptic technique and infection control measures are used, but infection cannot be eliminated as a risk. I agree to contact the practice if I develop increasing redness, warmth, swelling, drainage, significant pain, or fever.

8. Pregnancy and breastfeeding

Certain fluids, vitamins and medications given intravenously may be unsafe in pregnancy, may cross the placenta, or may pass into breast milk. If there is any chance you are pregnant, or if you are breastfeeding, tell the clinician before treatment begins so the plan can be reviewed or declined.

9. After your treatment

You may feel dizzy, lightheaded or nauseated after an infusion, and some medications can cause drowsiness. Do not drive or operate machinery until you know how you feel. Arrange transportation if you have been told your treatment may make you drowsy.

> **Call us at (863) 838-7825 if you develop** hives, itching, mild swelling, fever, or increasing pain, redness or swelling at the IV site after you leave. **For chest pain, severe difficulty breathing, severe allergic reaction, fainting, or new neurologic symptoms, call 911 or go to the nearest emergency department immediately. Do not wait.**

10. Information you must give us

Accurate information is essential to your safety. I have disclosed, to the best of my knowledge:

- ☐ All known medication allergies
- ☐ All current prescription medications
- ☐ Over the counter medications
- ☐ Vitamins and supplements
- ☐ Relevant medical conditions
- ☐ History of heart disease
- ☐ History of kidney disease
- ☐ History of liver disease
- ☐ History of significant high blood pressure
- ☐ Pregnancy or possible pregnancy, or breastfeeding
- ☐ Previous reactions to medications or IV therapy
- ☐ Other relevant medical information

Additional information

Failure to disclose relevant information increases the risks of treatment.

11. Alternatives and your right to decline

Oral fluids and rest
Oral electrolyte replacement
Observation without treatment
Treatment of an underlying medical condition
Evaluation by another healthcare provider
Urgent care, emergency department or hospital care

I understand I have the right to decline IV therapy, and to stop treatment at any time after it has started. The clinician may also stop treatment at any time if continuing is unsafe or medically inappropriate.

12. No guarantee of benefit

IV therapy may not improve my symptoms or my medical condition. No guarantee has been made about the outcome, effectiveness, duration of benefit, or relief of symptoms. My symptoms may have an underlying cause that requires further evaluation. An outpatient IV service is not a substitute for an emergency department, a hospital, or ongoing care from a primary physician.

13. Privacy and financial acknowledgment

- ☐ I have been offered a copy of the practice's Notice of Privacy Practices, which explains how my health information may be used and disclosed.
- ☐ I understand IV therapy is generally self-pay and is typically not covered by insurance or Medicare, that the cost was disclosed to me before treatment, and that I am responsible for payment.
- ☐ I was offered a copy of this signed consent form.

14. This form does not waive your legal rights

This document records informed consent and acknowledgment of the risks that are inherent in IV therapy even when care is provided properly. It does not waive, release or limit any right I may have to bring a claim for medical negligence or for care that fails to meet the applicable standard of care. The practice and its clinicians remain responsible for providing care consistent with accepted professional standards.

15. Patient acknowledgment

- ☐ I have read this consent form
- ☐ I understand the nature of IV fluid therapy
- ☐ The risks and complications were explained to me
- ☐ I understand complications can occur despite proper care

- ☐ I disclosed my conditions, medications and allergies
- ☐ I had the opportunity to ask questions
- ☐ My questions were answered to my satisfaction
- ☐ I understand no particular result is guaranteed
- ☐ I understand I may refuse or stop treatment
- ☐ I voluntarily choose to proceed with IV therapy

PATIENT CERTIFICATION

I certify that I have read and understand this document, that I had sufficient opportunity to ask questions, and that I voluntarily consent to the IV therapy described to me.

Patient name (print) _____ Patient signature _____ Date and time _____

IF SIGNED BY AN AUTHORIZED REPRESENTATIVE

Representative name (print) _____ Relationship to patient _____

Basis of authority to consent _____ Signature _____ Date and time _____

CLINICIAN ATTESTATION

I discussed the proposed IV therapy with the patient, including its purpose, the reasonably foreseeable risks, the potential benefits, and the available alternatives including no treatment. The patient had the opportunity to ask questions and indicated that those questions were answered satisfactorily.

Clinician name and credential (print) _____ Signature _____ Date and time _____

Optional and separate: photography and marketing release

You do not have to sign this to receive treatment, and declining will not affect your care in any way. Leave it blank if you prefer.

- ☐ I permit the practice to use photographs or video of me for marketing or educational purposes. I may withdraw this permission in writing at any time.
- ☐ I do not give permission.

Signature (only if granting permission) _____ Date _____