



Setareh Tais, ND

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Consent for Intravenous & Intramuscular Vitamin Injections

I have informed my doctor of any known allergies to drugs or other substances, or of any past reactions to anesthetics. I have informed the doctor 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:

- The procedure involves inserting a needle into a vein or muscle and injecting the prescribed solution.
- Alternative to IV/IM therapy are oral supplementation and/or dietary and lifestyle changes
- Risk of IV/IM therapy include:
 - Occasionally to commonly: discomfort, bruising and pain at the site of injection
 - Rare: inflammation of the vein used for injection, phlebitis
 - Extremely rare: severe allergic reaction, anaphylaxis, cardiac arrest and death
- Benefits of IV therapy include:
 - Injectables are not affected by stomach or intestinal absorption problems
 - Total amount of infusion/injection is available to the tissues
 - Nutrients are forced into cells by means of a high concentration gradient
 - Higher doses of nutrients can be given than possible by mouth without intestinal irritation

I am aware that other unforeseeable complications could occur. The doctor has explained these risks to me as well as other options for treatment including receiving no treatment and the probable outcomes. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answer.

I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to the procedure described above with any different or further procedures which, in the opinion of my doctor, may be indicated.

Patient's Name Signature

Guardian/Personal Representative's Signature

Patient's Name (Printed)

Guardian/Personal Representative's Name (Print)

Date

Relationship/Representative's Authority