ASAP IVs
San Diego's IV Hydration Experts

I hereby authorize the following procedure: administration of intravenous crystalloid solution and if I so choose, the administration of anti-nausea and anti-inflammatory medications and/or additional vitamins, supplements, and minerals. 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, improving fatigue, improving nausea; etc. The principal side effects that may accompany intravenous administration of the above include (but is not limited to):

-burning and stinging at the site of infusion, or if IV infiltrates into surrounding tissue

-bruising, bleeding or infection at infusion site

-muscular spasms, weakness, or fatigue

-allergic reactions (rare)

-local thrombophlebitis (very rare)

-venous air embolism of catheter embolization (very, very rare)

This procedure is not curative of any disease. 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 doctors and other health care professionals from ASAP IVs as is appropriate and necessary for my care.

I understand that I may suspend or terminate my treatment at any time by informing my medical provider. 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 the 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 medically unnecessary or not currently indicated.

I hereby place myself under your care for intravenous crystalloid administration therapy, and agree to proceed fully understanding the information presented above. 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.

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Medical History Negative For:

Congestive heart failure or cardiovascular disease

Chronic kidney disease or renal failure

Chronic liver disease or cirrhosis

NKDA or _____

I hereby acknowledge that I understand that my Insurance coverage, including Medicare, may not pay for this Non-covered service, and that all services ancillary to this treatment may be also Non-covered services and not reimbursable. I agree to be responsible for payment at the time of service for all services, including Non-covered services.

___ I agree that ASAP IVs may use pictures of my treatment or likeness for the purpose of online promotional material including Instagram, and provide my consent for this purpose.

Patient Name: _____ DOB _____/____/_____

Print Signature: _____ Date: _____

Patient Email: _____ Phone: _____

STAFF USE ONLY:

☐ Client medical history discussed and reviewed ☐ Client has no medical contraindications to IV therapy

IV Insertion Site (circle): LEFT RIGHT Hand Forearm AC

Number of attempts (circle): 1 2 3 IV Catheter Gauge: ☐ 20g ☐ 22g

Starting Time: Starting BP/HR: Finish Time: Finish BP/HR:

☐ All medications checked and verified to be non-expired prior to administration.

IV Package (includes standard dosages):

Add-Ons:

Complications (☐ None):

Medical Provider: _____