ReviVAL
Mob Services

Consent Form FOR IV THERAPY

INFORMED CONSENT FOR IV THERAPY

Patient Name: _____Date of Birth: _____Phone Number: _____Emergency Contact:_____

Purpose of IV TherapyIV therapy is a medical treatment that involves the administration of fluids, electrolytes, vitamins, or medications directly into the bloodstream. The purpose of IV therapy is to address specific medical needs, such as hydration, nutrient replenishment, or symptom management.

Procedures and BenefitsThe process involves the insertion of an intravenous (IV) catheter into a vein, typically in the arm. The IV will administer fluids or medications as discussed. The goal of this therapy is to enhance hydration, restore electrolytes, deliver vitamins, and improve overall wellness. The specific treatment plan will be discussed between the patient and the healthcare provider.

Potential Risks and ComplicationsWhile IV therapy is generally safe, certain risks may arise, including but not limited to:

- Pain, bruising, or swelling at the site of insertion
- Infection at the IV site
- Blood clots or inflammation (phlebitis)
- Allergic reactions to fluids or medications used
- Vein irritation or leakage

Should any of these complications occur, immediate medical attention will be provided.

Consent for TreatmentI, the undersigned, consent to the administration of IV therapy. I have had the procedure and its potential risks, benefits, and alternatives explained to me. I understand that my healthcare provider will determine the best course of action based on my medical needs and that I can ask questions at any time.

I acknowledge that I have provided an accurate medical history and understand that withholding information could affect my treatment. I also understand that I can refuse or discontinue the treatment at any time.

ConfidentialityAll medical information shared will be treated with strict confidentiality as required by law.

Signature and DateBy signing below, I acknowledge that I have read and understood the information provided and give my consent to receive IV therapy.

Patient Signature: _____Date: _____

Healthcare Provider Name: _____

Healthcare Provider Signature: _____Date: _____