Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_

Desired outcome for the use of IV Therapy? (General wellbeing, athletic performance, post-COVID recovery, medical or psychiatric illness, weight loss, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please check all that apply:

\_\_\_Hypertension

\_\_\_Single COVID infection

\_\_\_Multiple COVID infection

\_\_\_# of COVID Vaccinations inc. boosters

\_\_\_Swelling

\_\_\_Chest Pain

\_\_\_Cardiovascular Disease

\_\_\_Congestive Heart Failure

\_\_\_Arrhythmia

\_\_\_Bleeding disorder

\_\_\_Kidney disease

\_\_\_Liver disease

\_\_\_Cancer

\_\_\_Diabetes Type I

\_\_\_Diabetes Type II

\_\_\_Seizures (with or without epilepsy)

\_\_\_Pseudo Seizures

\_\_\_Asthma/COPD/Pulmonary diseases or disorders

\_\_\_Migraines

\_\_\_Tremors

\_\_\_Parkinsons

\_\_\_Surgical History

\_\_\_Mental Health Concerns

\_\_\_Previous/Current use of alcohol

\_\_\_Previous/Current use of psilocybin/ketamine

\_\_\_Chronic Pain

\_\_\_Fibromyalgia

\_\_\_Chronic fatigue

\_\_\_None of the above

Prescribed medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies and Sensitivies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant, trying to become pregnant, breastfeeding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to receive an intravenous (IV) drip treatment.

* I understand that the purpose of the IV drip is to administer fluids, medications, or nutrients directly into my bloodstream.
* I acknowledge that I have received information regarding the procedure, its benefits, potential risks, and alternative treatment options.
* I will have an opportunity to ask questions at any point and will proceed only if I get satisfactory answers.
* I understand that the IV drip treatment will be performed by a qualified healthcare professional who will follow established protocols and guidelines for its administration.
* The healthcare professional will also monitor me closely throughout the procedure to ensure my safety and well-being.
* I acknowledge that the potential risks associated with receiving an IV drip may include but are not limited to: - Infection at the injection site - Bleeding or hematoma formation - Allergic reactions to medications or solutions used in the IV drip - Air embolism if air enters the bloodstream - Infiltration or extravasation of fluids or medications into surrounding tissues.
* I understand that the healthcare professional will take appropriate measures to minimize these risks, such as using sterile equipment, properly securing the IV line, and closely monitoring the infusion site.
* I am aware that I have the right to refuse or discontinue the IV drip treatment at any time, and that I can discuss my concerns or request more information from the healthcare professional before making a decision.
* I understand that the results and benefits of the IV drip treatment may vary from person to person, and there are no guarantees regarding its effectiveness for my specific condition.
* I hereby release the healthcare facility, its employees, and healthcare professionals from any liability, claims, or damages that may arise from the administration of the IV drip treatment, except those resulting from their gross negligence or willful misconduct.

By signing below, I confirm that I have read and understood the information provided in this consent form. I authorize the clinic and its associated health professionals to collect personal and medical information as documented. In addition, I authorize the clinic and its associated health professionals to communicate with my medical team and family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I freely and voluntarily give my consent to undergo the IV drip treatment.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_