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Intravenous (IV) Infusion Therapy

Checklist of what to bring:

- ☐ Your completed Intravenous (IV) Therapy Intake Form
- ☐ A copy of your most recent bloodwork (including G6PD) is helpful
- ☐ Your signed Consent Form
- ☐ Make sure that you are well hydrated prior to your visit; we suggest drinking one to two 16oz. bottles of water. Dehydration can make it difficult to insert an IV.
- ☐ Make sure you eat something prior to you visit; we suggest a high protein snack, such as nuts, seeds, a protein bar, cheese, yogurt, or eggs. Low blood sugar can make you feel weak, light-headed, or dizzy.

During your first visit for IV Therapy infusions:

During the first visit, the healthcare practitioner will discuss your symptoms and desired outcomes. Based on this assessment, your IV infusion will be customized to address your needs. If you have any complex medical conditions, the healthcare practitioner may request that you obtain blood work and/or your PCP's approval prior to administering any IV infusions.

What to expect:

The IVs used during your Intravenous (IV) infusion therapy are exactly the same that you would find in a hospital. Instead of a clinical experience though, our IV infusions are given in a peaceful spa setting and leave you feeling calm, relaxed, and refreshed.

Depending on your customized IV cocktail, the infusion can be finished in as little as 20-30 minutes. Our friendly and attentive staff will keep you calm, cared for, and comfortable during your infusion. Patients find the experience tranquil and healing. Patients leave feeling vibrant, energized, and refreshed.

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Intravenous (IV) Infusion Therapy Intake Form

Patient Information:

Name: _____ Date: _____

Date of Birth: _____ (MM/DD/YYYY) Sex: M / F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____

Occupation: _____ Email address: _____

In case of emergency, please contact:

Name: _____ Phone: _____

What are your main complaints? (Please check all that apply)

- ☐ Fatigue or low energy
- ☐ Stress
- ☐ Poor diet due to busy lifestyle
- ☐ Brain fog or trouble concentrating
- ☐ Low mood or depression
- ☐ Headaches or migraines
- ☐ Weight gain/difficulty losing weight
- ☐ Asthma and allergies
- ☐ Recent surgical procedure
- ☐ Recent illness
- ☐ Cold or flu symptoms
- ☐ Facial wrinkles or fine lines
- ☐ Dull or dry skin
- ☐ Malabsorption issues
- ☐ Other: _____

Which statements best describe why you are here today? (Please check all that apply)

- ☐ I want to have more energy and feel better overall
- ☐ I want to do everything I can to nourish my body
- ☐ I want to do everything I can to enhance my weight loss efforts
- ☐ I want to prevent getting sick
- ☐ I want to recover quickly from my surgery or illness
- ☐ I want to slow the aging process
- ☐ I want to feel and look younger
- ☐ I want to have smoother, brighter, and more vibrant skin
- ☐ I want to cleanse my body of toxins
- ☐ I want to recover quickly from a hangover
- ☐ Other: _____

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Medical History

Are you pregnant or breastfeeding? Yes / No
Date of last chemistry screen or other lab testing: _____
Have you ever been told that you have an electrolyte imbalance or other abnormal labs?
(Please check all that apply)

- ☐ Hypermagnesemia (high magnesium levels)
- ☐ Hypercalcemia (high calcium levels)
- ☐ Hypokalemia (low potassium levels)
- ☐ Hemochromatosis (high iron levels)
- ☐ Other: _____

Are you diabetic? Yes / No
Do you smoke? Yes / No If yes, how much do you smoke? _____
How many alcoholic drinks do you consume in a week? _____
Do you use any recreational drugs? Yes / No
If yes, which ones and how often? _____
Do you take Digoxin (Lanoxin) for heart problems? Yes / No
Do you take any diuretics or water pills? Yes / No If yes, please list: _____
Do you take any steroids e.g., Prednisone? Yes / No If yes, please list: _____
Do you have any medication or food allergies? Yes / No If yes, please list: _____
Do you have any of the following conditions? (Please check all that apply)

- ☐ Blood pressure problems (high or low)
- ☐ Heart Problems
- ☐ Stroke or "mini-stroke"
- ☐ Kidney problems
- ☐ Kidney stones
- ☐ Asthma
- ☐ Optic nerve atrophy or Leber's Disease
- ☐ Sickle cell Anemia
- ☐ G6PD Deficiency
- ☐ Sarcoidosis
- ☐ Parathyroid problems (high levels)

Please list any other medical conditions you have (not mentioned above):

_____

_____

Please list all surgical procedures you've had with approximate dates:

_____

_____

Is there anything else you would like the nurse and physician to know?

_____

_____

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Current Medications, Over-the-Counter Drugs, and Supplements

Please list everything that you are currently taking:

Name – Strength – Frequency – Condition being treated

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Intravenous (IV) Infusion Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy.

(Initials)_____ I have informed the healthcare practitioner of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the healthcare practitioner of my medical history.

(Initials)_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

(Initials)_____ 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.

(Initials)_____ I understand that before IV Infusion Therapy, I need to:

1. Complete blood work (CBC, Comprehensive Metabolic Panel, G6PD, Ceruloplasmin, U/S)
2. Arrive hydrated – if dehydration occurs due to the IV, you will be given fluids to correct the dehydration.
3. Arrive having eaten a meal or brought snacks with you

(Initials)_____ I understand that the following will reduce the efficacy of IV Infusion Therapy and that it may take more treatments to reach optimal health:

1. Cigarette smoking
2. Caffeine consumptions (increases vitamin C excretion)
3. Poor diet: processed foods, high sugar intake, nutrient deficient diets
4. Heavy metal toxicity

(Initials)_____ I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include, but are not limited to:
    a. Occasionally: Discomfort, bruising and pain at the site of injection, a fall in blood pressure (staff will stop the infusion and provide IV fluids to help it return to normal).
    b. Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
    c. Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest, and death.
    d. Long-term adverse consequences of these therapies may be possible but are unknown at this time. IV therapy is not FDA-approved to treat or prevent any illness or disease.
4. Benefits of intravenous therapy include:
    a. Injectables are not affected by stomach or intestinal absorption problems.
    b. Total amount of infusion is available to the tissues.
    c. Nutrients are forced into cells by means of a high concentration gradient.

d. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) and/or physician(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) and/or physician(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all of my questions answered.

(Initials)_____ 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 IV Infusion Therapy, including any other procedures which, in the opinion of my physician(s) or others associated with this practice, may be indicated.

(Initials)_____ I understand that having IV Infusion Therapy can cause symptoms such as fever, fatigue, headaches, or nausea; please call if you have concerns or questions following your IV.

My signature below confirms that:

1. I understand the information provided on this form and agree to all the statements made above.
2. Intravenous (IV) Infusion Therapy has been adequately explained to me by my nurse and/or physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.
5. I release the healthcare practitioner, Flatiron Functional Medicine, and all the staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.
6. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.
7. To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

Patient's Name (please print): _____ Date of Birth: _____

Patient's Signature: _____ Date: _____

Healthcare Practitioner's Signature: _____ Date: _____

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Discharge Instructions for Intravenous (IV) Infusion Therapy

How to care for yourself after your IV Vitamin Therapy infusion:

- Apply pressure to site for 2 minutes after IV has been removed
- Keep Band-Aid in place for 1 hour
- Warm packs and elevating your arm can be used for any bruising at the site
- Cold packs can be used for pain relief and to decrease any swelling at the site
- Any swelling should be significantly reduced in 24 hours
- Post IV infusion symptoms are uncommon. Dehydration is the cause of most symptoms and concerns.
- We encourage you to drink at least 16-32oz. of water after your IV infusion.
- If enough water is not consumed, you may experience any of the following symptoms: headaches, nausea, joint pain, blurred vision, cramping (GI and/or muscular), mental confusion, and/or disorientation.

Most patients experience significant overall improvements:

- Better energy
- Better mental clarity
- Improved sleep
- Improvement of their complaints
- Overall feelings of well-being

Patients commonly report one of two patterns after an IV Vitamin Therapy infusion:

- Patients generally feel better right away. Due to a busy lifestyle, many people are chronically dehydrated and deficient in vitamins and minerals, causing them to not feel well. Once the patient is hydrated and the nutrients are replaced, their symptoms improve quickly.
- Patients sometimes feel tired or unwell. These patients are generally in the process of detoxifying. When toxins are pulled out of tissues, they re-enter the blood stream. They remain poisons, but they are now on their way OUT instead of on their way IN. Even when patients do not feel well at this stage, the process is one of healing and cleansing. After this period, an overall improvement in one's sense of well-being is generally reported.

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How often will I need IV Vitamin Therapy infusions?

The number and frequency of treatments will vary depending on certain factors:

- Condition(s) being treated
- Current health status of the patient
- Response of the patient to the treatments

A general estimate of the number of treatments needed is discussed during the first visit. As we go along, we will develop a more specific treatment plan. *Most patients will require at least 5-10 treatments*. Depending on the response, some patients will then go on to maintenance therapy with occasional treatments.

All of the following can reduce the efficacy of IV Therapy and that it may take more treatments to reach optimal health:

- Cigarette smoking
- Caffeine consumption (increases vitamin C excretion)
- Poor diet (i.e., processed foods, high sugar intake, nutrient deficient diet)
- Heavy metal toxicity

Call Flatiron Functional Medicine or your Primary Care Physician for:

- Any symptoms you are not comfortable with
- If any of the following are progressively worsening after your IV infusion:
    - Significant swelling over the IV site
    - Redness over the vein that is increasing in size
    - Pain in the vein/arm that is not improving over an 8-12 hour period
    - Headache that does not resolve with increased hydration or over-the-counter pain relievers like Aspirin, Acetaminophen, or Ibuprofen.

If you feel like you are having a life threatening emergency, please call 911.

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