Healing Path
Integrative Medicine, PLLC
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Informed Consent for Antibiotic Therapy

I, _____ , hereby give consent to Healing Path Integrative Medicine to prescribe oral and/or intravenous antibiotic therapy for the treatment of rheumatologic disease, neurological disease, chronic lyme disease, or degenerative disease upon my request. I understand that different modes of therapy are generally used to treat these conditions.

Although strong scientific research supports the use of antibiotic therapy in rheumatoid arthritis and some other degenerative and/or autoimmune diseases, this treatment approach is still considered "non-standard" and is not accepted by most physicians, including the use of long-term antibiotics for lyme disease.

I have also been informed that I may experience possible adverse effects, including but not limited to:

- allergic reaction that ranges from mild (skin rash, nausea, vomity) to severe (difficulty in breathing, severe allergic reaction) ;
- Herxheimer reaction (temporary worsening of symptoms or other conditions);
- Fatigue; sun sensitivity; low white blood cell count; dizziness; stomach/bowel upset;
- Intestinal or vaginal yeast overgrowth (candidiasis);
- Infectious diarrhea caused by an overgrowth of C. difficile in the colon (psuedomembranous colitis).
- Adverse effects on liver, kidneys, gallbladder, or other organs.

Other drugs may be given to make side effects less serious and uncomfortable. Many side effects go away soon after the drugs are stopped. In some cases, side effects can be serious, long lasting or permanent. There also may be other side effects that we cannot predict.

I understand that Healing Path Integrative Medicine is committed to doing everything possible to minimize these potential complications, but some risks still exist.

It is especially important that I have been educated about the risks associated with antibiotic-induced infectious diarrhea. This risk can occur with the use of any antibiotic, but is especially associated with the use of Clindamycin (Cleocin). The warning in the PDR reads:

"Clindamycin therapy has been associated with severe diarrhea which may end fatally. Therefore, it should be reserved for serious infections where less toxic antimicrobial agents are inappropriate,…/….a toxin produced by Clostridia difficile is one primary cause of antibiotic-associated colitis. The colitis is usually characterized by severe, persistent diarrhea and severe abdominal cramps and may have passage of blood and mucous. When significant diarrhea occurs, the drug should be discontinued…"

I agree to use probiotics (acidophilus and saccharomyces boulardi) regularly to decrease this risk. I

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agree that if I develop unusual or severe diarrhea during (or within one month after) antibiotic treatment, I will stop the antibiotics and immediately consult Healing Path Integrative Medicine or get immediate medical care elsewhere. I understand that I should not use anti-motility agents to stop such diarrhea, as they may allow toxins to stagnate in my colon and be absorbed, increasing toxicity. The proper treatment for such diarrhea is oral vancomycin or oral metronidazole.

I understand that non-standard Antibiotic Therapy should not be used if I am pregnant, and it may decrease the effectiveness of oral contraceptive pills.

I understand that this is a widely-used therapy among Integrative Health Practitioners, but is not considered a mainstream therapy among conventional physicians. I acknowledge that I have been given no guarantees or warranties, expressed or implied, regarding the outcome of this procedure. I acknowledge that I have been asked to consider continuing care provided by any specialists and my primary care physician.

I have read the above and my questions about Antibiotic Therapy have been answered to my satisfaction. With this information, I hereby request non-standard Antibiotic Therapy and I consent to these treatments. I feel that I fully understand what I am signing.

Signature of patient _____ Date_____

Printed Name of patient _____

Signature of Witness _____ Date_____