IV Iron Infusion

Administration Patient Consent to Medical Treatment or surgical

Procedure and acknowledgement of receipt of medical information

**Information about this document-read carefully before signing**

**TO THE PATIENT:** You have been told that you should consider medical treatment/surgery. Louisiana law requires that I tell you (1) the nature of the(Your) condition, (2) the general nature of the medical treatment, (3) the risk of the proposed treatment, as defined by the Louisiana Medical Disclosure Panel or as determined by your doctor, and (4) reasonable therapeutic alternatives, and (5) risk of no treatment.

You have the right, as a patient, to be informed about your condition and the recommended medical, surgical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. I have already discussed with you the common problems and risks. I wish to inform you as completely as possible. Please read the form carefully. Ask about anything you do not understand, and I will be pleased to explain it.

**1. PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. AUTHORIZING PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. a. TREATMENT/PROCEDURE/MEDICATIONS:** IV Iron Infusion

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**b. BENEFITS/PURPOSE:** Iron Infusion helps replace iron in the blood stream. Iron is necessary to help the body produce hemoglobin which carries oxygen throughout the body.

**4. PATIENT CONDITION:** Patient's diagnosis, description of the nature of the condition or ailment for which the medical treatment, surgical procedure or other therapy described in item number 3 is indicated and recommended. iron deficiency anemia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. MATERIAL RISKS OF TREATMENT PROCEDURE**: a. All medical or surgical treatment involves risks. Listed below are those risks associated with this procedure that I believe a reasonable person in your (the Patients) position would likely consider significant when deciding whether to have a forego the proposed therapy. Please ask your physician if you would like additional information regarding the nature or consequences of these risks, their likelihood of occurrence, or other associated risks that you might consider significant but may not be listed below. Mild side effects include muscle and abdominal cramps; diarrhea; leg cramps; loss of appetite; nausea; stomach pain; tiredness; vomiting; weakness; altered taste, constipation, dizziness, elevated blood pressure.

b. Additional risks(if any) particular to the patient because of a complicating medical condition, may include but are not limited to: Severe allergic reactions (rash; hives; itching; difficulty breathing; tightness in the chest; swelling of the mouth, face, lips, or tongue); burning, numbness, or tingling; calf or leg pain, redness, tenderness, or swelling; chest pain; cough; dizziness or light-headedness; fainting; fast, slow, or irregular heartbeat; fever or chills; flushing; increased sweating; muscle weakness; pain, redness, or swelling at the injection site; severe or persistent nausea, vomiting, or headaches; severe pain in the chest, back, groin, or sides of the body; shortness of breath or other breathing problems; wheezing

c. Risks generally associated with any surgical treatment/ procedure, including anesthesia are: death, brain damage, disfiguring scars, quadriplegia (paralysis from neck down) paraplegia (paralysis from waist down), the loss of function of any organ or limb, infection, bleeding, and pain.

6. Reasonable therapeutic alternatives and risks associated therewith:

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7. RISKS OF NO TREATMENT: Worsening of underlying condition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. ACKNOWLEDGEMENT AUTHORIZATION AND CONSENT:

NO GUARANTEES: All information given to me and, in particular, all estimates made as to the likelihood of occurrence if risks of this procedure or as to the prospects of success, are made in the best professional judgement of my physician. The possibility and nature of complications cannot always be accurately anticipated and, therefore, there is and can be no guarantee, either expressed or implied, as to the success or other results of the medical treatment or surgical procedure.

ADDITIONAL INFORMATION: Nothing has been said to me, no information has been given to me, and I have not relied upon any information that is inconsistent with the information set forth in this document.

PARTICULAR CONCERNS: I have had an opportunity to disclose to and discuss with my physician providing such information, those risks or other potential consequences of the medical treatment or surgical procedure that are of particular concern to me.

QUESTIONS: I have had an opportunity to ask, and I have asked, any questions I may have about the information in this document and any questions I have about the proposed treatment or procedure, and all such questions were answered in a satisfactory manner by my physician.

AUTHORIZED PHYSICIAN: the physician (or a physician group) authorized to administer or perform the medical treatment, surgical procedures or other therapy described in item 3 is named below. Your care may involve the participations of physicians in training under the supervision of credentials physicians. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN CERTIFICATION: I hereby certify that I have provided and explained the information set forth, herein including any attachment, and answered all questions of the patients, or the patient’s representative, concerning the medical treatment or surgical procedure, to the best of my knowledge and ability.

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

Signature of the physician Date/time

**CONSENT**

CONSENT: I hereby authorize and direct the destinated authorized physician/ group, together with associates and assistance of his choice, to administer or perform the medical treatment or surgical procedure described in item 3 of this consent form, including any procedures or services as they may deem necessary or reasonable, including the administration or any general or regional anesthetic agent, x-ray or other radiological service, laboratory services, and the disposal of any tissues removal during a diagnostic or surgical procedures, I hereby consent thereto.

I understand that there may be a need for a sales representative present during my procedure to provide technical advice to the physician. I understand that there may be an observe present and/or the use of photos, film or video during my procedure for educational purpose.

I have read and understand all the information set forth in this document, including any attachment, and all the blanks were filled in prior to signing. This authorization for and consent to medical treatment or surgical procedures in and shall remain valid until revoked.

I acknowledged that I have had the opportunity to ask any questions about the contemplated medical procedures or surgical procedures described in item 3 of this consent form, including risk, and acknowledge that my questions have been answered to my satisfactions.

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Patients or person Authorized to consent Date/time Witness Date/time

If someone other than the patient’s signs consent, state the reason and relationship.