IV Therapy Consent Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Consent to IV Therapy

I acknowledge that I have been informed about the procedure, potential benefits, risks, and possible side effects of intravenous (IV) therapy. I have had an opportunity to ask questions and all my questions have been answered to my satisfaction.

Check to confirm understanding and consent:

- [ ] I understand the purpose and potential side effects of IV therapy.
- [ ] I voluntarily consent to IV therapy.
- [ ] I have had the opportunity to ask questions.

Allergies

Current Medications

Medical History

Patient Signature

Date

Provider/Witness Signature

Date