Frontier
INFUSION CENTER

INFORMED CONSENT FOR INTRAVENOUS (IV) THERAPY/MEDICATION INFUSION

Patient Name:_____ Date of Birth: _____

Your Provider _____ has prescribed an intravenous (IV) infusion of _____ to treat your medical condition of _____.

My provider has reviewed the medication-specific risks and side effects with me and answered my questions _____(initials).

General risks of IV therapy may include, but are not limited to:

- Pain, bruising, or bleeding at the IV site
- Swelling or infiltration (fluid leaking into tissue)
- Infection at the IV site
- Phlebitis (inflammation of the vein)
- Allergic reaction, ranging from mild rash to severe anaphylaxis
- Headache, dizziness, nausea, or changes in blood pressure
- Electrolyte imbalance (for certain infusions)

Patient Responsibilities

- Inform staff of any allergies, medical conditions, or prior reactions to IV therapy.
- Report any unusual sensations (such as itching, shortness of breath, chest pain, or swelling) immediately during the infusion.
- Follow after-care instructions provided by the infusion staff.

Acknowledgement & Consent

I have had the opportunity to ask questions about this infusion therapy, and all my questions have been answered to my satisfaction. I understand the purpose, potential benefits, risks, and alternatives. I voluntarily consent to receive IV infusion therapy with the medication listed above.

Patient / Legal Guardian Signature: _____ Date: _____

Provider / Nurse Signature: _____ Date: _____