Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Intravenous Therapy (IV) Initial Intake & Consent

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Address: _____

City:_____ Postal Code:_____ Phone: _____ Cell: _____

Emergency Contact. _____

Email: _____ Occupation: _____

How did you hear of Visionary Health? _____

Please list your health concerns:

_____

_____

Are you currently being treated by any other physician(s) or healthcare practitioners?

_____

HEALTH HISTORY:

Height _____ Current Weight _____ Approx. weight 1 year ago: _____

Blood type: A ☐ B ☐ AB☐ O☐

Allergies: (please list any know allergies including medications, environmental & food related)

_____

_____

Medications: (please list all of your prescription and non-prescription medications including birth control and aspirin, etc.)

_____

_____

Supplements: (please list any vitamins, minerals or other natural supplements your are taking, with doses if known

_____

_____

Accidents/injuries/hospitalizations/surgeries (date and type)

_____

_____

_____

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Immunizations: (please check any immunizations you have had and note any reactions)

- Diphtheria, Pertussis, Tetanus, Polio, Hib _____
- MMR (measles, mumps, rubella) _____
- Influenza (Flu shot) _____
- Hepatitis A and/or B _____
- HPV (Gardasil) _____
- other (please list) _____

Family Medical History: (please check areas pertaining to blood relatives NOT including yourself)

- ☐ Alcoholism
- ☐ Asthma
- ☐ Anxiety
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Hay fever/allergies
- ☐ Heart disease/stroke
- ☐ Herpes
- ☐ High Blood pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Neurological disorder
- ☐ Obesity
- ☐ Substance Abuse
- ☐ Thyroid problems
- ☐ Others_____
  _____
  _____

Life Style:	Daily	Weekly
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____
Coffee/Caffeine	_____	_____
Dairy	_____	_____
Exercise	_____	_____
Meditation	_____	_____
Sweets	_____	_____
Other	_____	_____

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Informed Consent- Intravenous Therapy Procedures

Name of Patient:_____
Procedure:_____
Physician or Nurse Practitioner performing procedure:_____

1. Visionary Health Medical Educational Clinic provides facilities and personnel to assist in the performance of intravenous therapy. You 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 you had had an opportunity to receive such information and to give your informed consent.
    a. The procedure involves inserting a needle into your vein or muscle and injecting the formula described above by your physician.
    b. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
    c. Risks of intravenous therapy include:
        i. Discomfort, bruising and pain at the site of injection.
        ii. Inflammation of the vein used for injection, phlebitis.
        iii. Severe allergic reaction, anaphylaxis, cardiac arrest and death.
    d. Benefits of intravenous therapy include:
        i. Injectables are not affected by stomach or intestinal disease.
        ii. Total amount of infusion is available to the tissues.
        iii. Nutrients are forced into cells by means of a high concentration gradient.
        iv. Higher doses of nutrients can be given than possibly by mouth, without intestinal irritation.
2. You have the right to consent to or refuse any proposed treatments at ay time prior to its performance. Your signature on this form affirms that you have given your consent of the procedure(s) described above with any different or further procedures, which in the opinion of your physician, may be indicated.
3. The procedure will be performed by or under the direction of the physician named above with qualified medical assistants.

Your signature below means that:

a) You understand the information provided on this form and agree to the foregoing.
b) The procedure(s) set forth above has been adequately explained to your by your physician.
c) You have received all the information and explanation you desire concerning the procedure.
d) You authorize and consent to the performance of the procedure(s).

Date:_____ Time:_____ Signature:_____

If signed by a representative, indicate relationship:_____

Witness Name/ Signature:_____