SUNSHINE COAST
INFUSIONTHERAPIES

FULL NAME :	
D.O.B :	
PHONE :	
YOUR EMAIL :	
EMERGENCY CONTACT :	
EMERGENCY CONTACT PHONE :	
HOW DID YOU HEAR ABOUT US :	
POSTCODE :	
PLEASE EXPLAIN WHAT YOU WOULD LIKE TO ACHIEVE FROM USING OUR SERVICES :	

0432 935 150 info@scitmail.com.au sunshinecoastinfusiontherapies.com.au

MEDICAL INFORMATION Please list any medications you are currently taking, the conditions associated with it and the respective doses.	

MEDICATIONS & CONDITIONS :

LIST ALL ALLERGIES YOU HAVE TO DRUGS, FOOD OR OTHER ITEMS :	

ARE YOU CURRENTLY UNDER MEDICAL CARE FOR ANY REASON? *IF YES, PLEASE EXPLAIN :*	YES NO

HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

ASTHMA AND/OR EMPHYSEMA *IF YES, PLEASE EXPLAIN :*	YES	NO
OBSTRUCTIVE SLEEP APNOEA	YES	NO
HOME OXYGEN	YES	NO
UNCONTROLLED HIGH BLOOD PRESSURE	YES	NO
CHEST PAIN, ANGINA, HEART ATTACK, IF YES, PLEASE EXPLAIN	YES	NO
PACEMAKER or DEFIBRILLATOR		
HEART DISEASE, ARTIFICIAL VALVES OR STENTS IN HEART (required)	YES	NO

HEART DISEASE, ARTIFICIAL VALVES OR STENTS IN HEART (required)	YES	NO
DIABETES - CONTROLLED OR UNCONTROLLED	CONTROLLED UNCONTROLLED	NO
CIRRHOSIS or LIVER DISEASE	YES	NO
SUFFERED A STROKE? *IF YES PLEASE EXPLAIN*	YES	NO
CHRONIC KIDNEY DISEASE	YES	NO
BLOOD THINNING MEDICATION *IF YES, PLEASE NOTE THE MEDICATION YOU ARE/WHERE TAKING*	YES	NO
HEPATITIS	YES	NO
FEVER or COLD	YES	NO
HIV	YES	NO

HAD SURGERY WHERE LYMPH NODES HAVE BEEN REMOVED FROM UNDER YOUR ARM AREAS? *IF YES, WHAT ARMS?*	YES	NO
ARE YOU TO HAVE CHEMOTHERAPY SOON?	YES	NO
HAVE YOU RECENTLY HAD CHEMOTHERAPY?	YES	NO
CAN YOU WALK ONE FLIGHT OF STAIRS WITHOUT RESTING?	YES	NO
DO YOU HAVE ANY ILLNESS OR PROBLEMS INCLUDING CHRONIC PAIN THAT WE NEED TO KNOW ABOUT? *IF YES, PLEASE EXPLAIN WHAT AND WHEN*	YES	NO
DO YOU HAVE A FEAR OF NEEDLES?	YES	NO
DO YOU HAVE A PHOBIA OF BLOOD?	YES	NO

DO YOU HAVE A PAST EXPERIENCE IN FAINTING OR DIZZINESS? *IF YES, WHAT ARE THE POTENTIAL CAUSES?*	YES	NO

IS THERE ANY LIMITATION IN THE MOVEMENT OF YOUR NECK OR JAW? *YOU SHOULD BE ABLE TO OPEN YOUR MOUTH AT LEAST TWO FINGERS IN WIDTH AND BE ABLE TO TILT YOUR HEAD BACK TO LOOK STRAIGHT UP*	YES	NO

LIMITATIONS

I understand that that an initial series of treatments could be recommended and that these treatments may extend over a number of weeks or months. I understand that the benefits of intravenous nutrient therapy are much greater if I follow a healthy lifestyle (non-smoking, weight control, proper exercise, proper diet and nutritional supplementation). I understand that as with any other treatment, I may not receive benefit because they do not occur predictably with every patient and in a small percentage of patients they may not occur at all.	AGREE	DO NOT AGREE

RISKS & COMPLICATIONS

I understand that intravenous nutrition therapy using Vitamins, Minerals, Amino Acids and other nutrients has been widely used in Europe and the USA for many years. However, with all medications or drugs, nutritional supplements may exhibit some side effects in certain individuals.	AGREE	DO NOT AGREE

Adverse effects from Intravenous Nutrition Therapy include but are not limited to:

- Discomfort, bruising and pain at the site of injection.	AGREE	DO NOT AGREE
- Inflammation, infiltration or infection at the site of the injection.	AGREE	DO NOT AGREE
- There is a potential to feel a warm sensation throughout your body, which is a normal feeling when magnesium is used in your treatment. If however you are in any discomfort or distress, please tell the professional immediately.	AGREE	DO NOT AGREE
- Possible fall in blood pressure, which can be related to magnesium in the IV. The professional will be presented able to help you by stopping the infusion/or providing some extra IV fluid to bring the blood pressure to normal.	AGREE	DO NOT AGREE
- Allergic reaction or Anaphylaxis to a nutrient, a needle, or other supplies used.	AGREE	DO NOT AGREE

- There is potential for dizziness, feeling fainter changes in blood pressure and blood glucose levels during or following your treatment due to some nutrients. Inform the professional immediately if you feel any of these systems.	AGREE	DO NOT AGREE
- Other rare, but possible side effects include: fever, nausea, oedema, upset stomach, difficulty breathing, arrhythmia's and stroke.	AGREE	DO NOT AGREE
- As with any treatment there is also a possibility of other unforeseen adverse effects.	AGREE	DO NOT AGREE
This is strictly a voluntary procedure. No treatment is necessary or required. Other alternative treatments, which vary in sensitivity, effects and duration, include oral supplementation and/or dietary and lifestyle changes.	AGREE	DO NOT AGREE
I, the Client, represent that I am at least 18 years of age, have read and understand this release form, and am competent to exercise this agreement. (If agree please go to next page)	AGREE	DO NOT AGREE
The Client is under 18 years of age or under the supervision of a Guardian. I have read and understood this release form. I, am Guardian sign this form as confirmation that I am competent to execute this agreement on behalf of the client.	AGREE	DO NOT AGREE

PLEASE CHECK AGREE OR DO NOT AGREE IF UNDER 18 YEARS OLD	AGREE	DO NOT AGREE
GUARDIANS FULL NAME		
GUARDIANS SIGNATURE		
DATE :		

CONSENT

I have read and fully understood the above paragraphs and discussed the risks, benefits and alternatives to this treatment	AGREE	DO NOT AGREE
I have had sufficient opportunity for discussion and to ask questions.	AGREE	DO NOT AGREE
I believe I have adequate knowledge to request this treatment and consent to the proposed treatment	AGREE	DO NOT AGREE
I accept the risks and complications associated with the procedure and there are no material circumstances preventing me from having this treatment	AGREE	DO NOT AGREE
I have provided an accurate medical history and I have not withheld any information	AGREE	DO NOT AGREE

I am of the opinion that my request for treatment is not for medical reasons and the personal psychological features that are associated with my request	AGREE	DO NOT AGREE
I have expressed my thought and feelings to the treating professional and consent to the treatment for the purpose of restoring and maintaining the health of my skin and body and my psychological wellbeing	AGREE	DO NOT AGREE

CONFIRM

PLEASE LIST ANY OTHER MEDICAL SYMPTOMS, INJURIES, ALLERGIES OR THINGS THAT WE SHOULD NO ABOUT	
YOUR FULL NAME:	
SIGNATURE:	
DATE:	