XYZ Home Health, Inc.

INTRAVENOUS THERAPY CONSENT

_____ #_____
Patient / Client Name

Patient / Client / Responsible Party is to initial each paragraph which is relevant to the treatment.

	I have been informed of the purpose and possible complications in intravenous therapy. I consent to the administration of this treatment in the home by the XYZ Home Health, Inc. RN as ordered by the physician.
	I understand that service from XYZ Home Health, Inc. is on a part-time / intermittent basis.
	I agree that my caregiver and/or I will assume responsibility for the care of the Intravenous in the absence of the XYZ Nurse.
	I have been instructed how to care for the intravenous and how to seek assistance between nursing visits.
	I consent to the administration of Intravenous Medication as ordered by my physician. I have been informed of possible side effects and complications.
	I consent to the insertion of intravenous needles as required to administer my intravenous therapy. I have been informed of possible side effects and complications.
	I have been informed that XYZ Home Health, Inc. has specific policies relating to the care I will receive. These provisions include the termination of service at my or my family's request, the request of my Physician, or by the decision of XYZ Home Health, Inc.
	I agree to abide by the terms and policies of XYZ Home Health, Inc.

I hereby acknowledge that I have read and understand the above consents and that I have received a copy of this consent.

_____ _____
Patient / Client Signature Date

_____ _____
Witness' Signature Date