

Infusion Treatment Consent

Informed consent for outpatient infusion therapy

PATIENT INFORMATION

LAST NAME

FIRST NAME

MIDDLE
INITIAL

DATE OF BIRTH

SEX

SOCIAL SECURITY NUMBER
(LAST 4)

PHONE

MAILING ADDRESS

CITY

STATE / ZIP

EMAIL ADDRESS

PREFERRED CONTACT METHOD

Treatment Information

PRESCRIBING PHYSICIAN

PHYSICIAN PHONE

OFFICE

DIAGNOSIS (AND ICD-10 IF KNOWN)

MEDICATION ORDERED

DOSE

FREQUENCY

ANTICIPATED DURATION OF THERAPY

Acknowledgment of Information & Consent

I understand that my physician has prescribed the medication identified above to be administered intravenously, subcutaneously, or by other parenteral route at Arbor Infusion Therapy. I acknowledge that the following information has been explained to me and that I have had an opportunity to ask questions:

- The nature and purpose of the prescribed treatment, including expected benefits.
- Common and serious risks and side effects, including but not limited to: infusion-related reactions (chills, fever, flushing, blood pressure changes), allergic reactions ranging from mild to severe (including anaphylaxis), increased risk of infection, and risks specific to my prescribed medication as discussed with my physician.
- Alternative treatments, including the option of receiving no treatment, and the consequences of those choices.
- The medications, fluids, and supplies that will be administered, including any pre-medications (such as antihistamines, acetaminophen, or corticosteroids) given to reduce the risk of infusion reactions.



- That treatment will be administered by a registered nurse under the supervision of a medical director, and that vital signs and tolerance will be monitored throughout the infusion.
- That, in the event of an emergency, Arbor staff will provide initial treatment per established protocols and may transport me to the nearest emergency facility.
- That I may withdraw consent and stop treatment at any time, and that doing so will not affect my future ability to receive care at Arbor Infusion Therapy.

I CONSENT TO TREATMENT. Having read and understood the above, I voluntarily consent to the infusion therapy ordered by my prescribing physician and to be administered by Arbor Infusion Therapy. I authorize Arbor staff to administer the prescribed medication, related fluids, and any reasonable and necessary care in the event of an adverse reaction. This consent remains in effect for the duration of my prescribed therapy course unless I revoke it in writing.

**PATIENT OR LEGALLY AUTHORIZED
REPRESENTATIVE SIGNATURE**

PRINTED NAME

**RELATIONSHIP TO PATIENT
(IF NOT SELF)**

DATE

WITNESSING ARBOR STAFF MEMBER SIGNATURE

PRINTED NAME

DATE

Form code: ARB-CONSENT-001 · Reviewed by Arbor medical director. If you do not understand any portion of this form, please ask a staff member before signing.