WOMAN RISING MIDWIFERY

Patient Intake Form

Woman Rising Midwifery
4123 University Avenue
Des Moines, IA 50311
562-505-7603
womanrisingmidwifery@gmail.com

INTAKE FORM FOR INTRAVENOUS AND INJECTABLE FORM

Date: _____

Name: _____ DOB:_____ Age: _____

Address:_____

Phone: _____Email: _____

Reason for visit: _____

Emergency Contact: _____

Please briefly describe why you are seeking IV infusion or injection therapy?

_____

_____

Allergies (Medications, foods, etc.):

_____

_____

Current Medications: (Please include OTC & supplements)

_____

_____

_____

_____

Please check any conditions that apply to you:

CARDIOVASCULAR

- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Valve Disorder
- ☐ Abnormal Rhythm
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Cardiac Surgery or Stents
- ☐ Congestive Heart Failure
- ☐ Peripheral Artery Disease
- ☐ Thrombosis or DVT
- ☐ Aneurysm
- ☐ Other Cardiac Disorder _____

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Pulmonary Hypertension
- ☐ Lung Cancer
- ☐ Other Lung Disorder _____

CANCER

- ☐ Location of cancer _____
- ☐ Chemotherapy
- ☐ Radiation

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- ☐ Lung Cancer
- ☐ Other Lung Disorder _____

GASTROINTESTINAL AND URINARY

- ☐ Acid Reflux
- ☐ Liver Disease
- ☐ Bladder Disease
- ☐ Hepatitis A, B, C
- ☐ Kidney Disease
- ☐ Other _____

PSYCHOLOGICAL

- ☐ Depression
- ☐ Anxiety or Panic Attacks
- ☐ Suicidal Ideations

WOMEN (non-menopausal)

- ☐ Last Menstrual Period _____
- ☐ Any chance you are pregnant? _____
- ☐ Are you breastfeeding? _____

PAIN

- ☐ CRPS
- ☐ Fibromyalgia

METABOLIC/ENDOCRINE/AUTOIMMUNE

- ☐ Hyper/Hypo Thyroid
- ☐ Rheumatoid Arthritis
- ☐ Diabetes Type I Type II
- ☐ Hx of DKA
- ☐ Lupus
- ☐ Other _____

NEUROLOGIC

- ☐ Stroke/TIA
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Seizures – date of last _____
- ☐ Alzheimer's

HEMATOLOGY

- ☐ Anemia (Iron Deficiency, Pernicious,
- ☐ Aplastic, Hemolytic, Sickle Cell)
- ☐ MTHFR
- ☐ G6PD Deficiency

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Degenerative Joint Disease
- ☐ Carpal Tunnel Syndrome
- ☐ Degenerative Disk Disease
- ☐ Fibromyalgia
- ☐ Other_____

Do you drunk alcohol or abuse any types of drugs? If so, please explain:

_____

_____

Have you ever had an electrolyte or fluid imbalance in the past? Such as low potassium, high sodium, etc.?

_____

_____

Would you like to tell us anything else that you feel like is important?

_____

_____

I attest that the information I have provided is true and accurate to the best of my knowledge:

_____. _____. _____

Signature Print name Date

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Checklist of what to bring:

▫ Your completed Intravenous (IV) Infusion Therapy Intake Form
▫ A list of all prescription medications, OTC medications, vitamins/supplements that you take
▫ A copy of your most recent bloodwork is helpful
▫ Your signed Consent Form (this form) and Provider Approval Form (if relevant).
▫ Your signed HIPPA Notice
▫ Make sure you are well hydrated prior to your visit. We suggest drinking 1-2 (16oz). bottles of water. Dehydration can make it difficult to insert an IV.
▫ Eat something prior to your visit. We suggest high protein snacks, such as nuts, a protein bar, cheese, yogurt or eggs. Low blood sugar can make you feel weak, light-headed or dizzy.

During your first visit for IV Vitamin Therapy infusions:

During the first visit, a Registered Nurse will discuss your main complaints and desired outcomes with you. The Registered Nurse will review your medical & surgical history and any medications you are taking. Based on this assessment, your infusion will be customized to address your individual needs.

What to expect:

The IVs used during you IV infusion therapy are exactly the same that you would find in a hospital. Instead of a clinical experience though, our IV infusions are given in a peaceful setting and leave you feeling calm, relaxed, and refreshed. All of our infusions last from 45-60 min. Our friendly and attentive staff will keep you calm, cared for, and comfortable during your infusion.

Intravenous (IV) Nutrient Therapy Consent Form

This document is intended to serve as informed consent for your IV Therapy.

(Initials)_____ I have informed the nurse of any known allergies to medications or other substances and of all current medications and supplements. I have informed the nurse of my medical history.

(Initials)_____ Intravenous infusion therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

(Initials)_____ I understand that IV Nutrient Therapy at Woman Rising Midwifery is only for otherwise healthy adults under the age of 65 and over the age of 18.

(Initials)_____ I understand that I 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 I have had an opportunity to receive such information and to give my informed consent.

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(Initials)_____ I understand that:
1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplements and/or dietary/lifestyle change.
3. Risks of intravenous therapy include but not limited to: a) Occasionally: Discomfort, bruising and pain at the site of injection. b) Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury. c) Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
4. Benefits of intravenous therapy include: a) Injectables are not affected by stomach, or intestinal absorption problems. b) Total amount of infusion is available to the tissues. c) Nutrients are forced into cells by means of a high concentration gradient. d) Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

(Initials)_____ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) to anticipate and or explain all risk and possible complications. I rely on the nurse(s) to exercise judgment during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all questions answered.

(Initials)_____ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV Therapy, including any other procedures which, in the opinion of my physician(s) or others associated with this practice, may be indicated.

My signature below confirms that:
1. I understand the information provided on this form and agree to the all statements made above.
2. Intravenous (IV) Nutrient Therapy has been adequately explained to me by my nurse.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Nutrient Therapy.

Patient's Name and Date of Birth– Please Print

_____
__

Patient's Signature and Date

_____
__

Registered Nurse or Physician's Name – Please Print

_____
__

Registered Nurse or Physician's Signature and Date

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Post Infusion Instructions

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Following your infusion and/or injection:

- Continue to wear dressing applied to the IV infusion site for at least 1 hour to prevent break through bleeding.
- You can apply cold packs for any post injection/infusion pain. If you are not pregnant, you may also take naproxen (Aleve) for discomfort.
- A light meal and 16 ounces of water are recommended after the infusion
- Monitor your IV site for redness, pain, warmth, or swelling. This could be a sign of infection or an adverse reaction. If this occurs, please call Woman Rising Midwifery at 562-505-7603.
- Continue routine follow up with your mental health and/or primary care provider for continued treatment and evaluation.
- If any mild side effects occur such as hives, nausea, fever, cramping, headaches, or any additional non-life-threatening symptoms, please call Woman Rising Midwifery at 562-505-7603 immediately. If it is after hours, then please report to your closest urgent care or emergency department.
- If any type of serious adverse events occurs such as diffuse hives, shortness of breath, trouble swallowing, chest pain, severe headache, changes in consciousness, increase pain/swelling in the arm that the infusion was given in, or anything else that is concerning, call 911 or report to the emergency department immediately.
- You can expect to feel improvements in your symptoms within 15-90 minutes of your infusion. These effects can last up to 1 to 1 and a half weeks.
- Patients can present for repeat infusions every 2 weeks unless determined otherwise by your treating provider.

Additional instructions:

_____
_____
_____
_____

- If you have any additional questions or concerns, please feel free to reach out to Woman Rising Midwifery via phone at 562-505-7603 or via email at womanrisingmidwifery@gmail.com.

- Your next appointment date and time: _____

- I acknowledge that I understand the instructions that need to be followed prior to and after my treatment. I certify that I will follow these instructions and notify Woman Rising Midwifery of any changes in my condition or drug/supplement use.

Printed patient name: _____

Patient signature: _____

Date:_____

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Indemnification Clause

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I, _____, agree to indemnify, defend, protect, and hold harmless the medical providers employed by Woman Rising Midwifery; and their respective officers, directors, employees, stockholders, assigns, successors and affiliates (Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgements, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by Woman Rising Midwifery; rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by Woman Rising Midwifery;; harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by Woman Rising Midwifery;. I am aware of the potential side effects associated with IV infusion and injectable therapies provided by Woman Rising Midwifery, accept all the risks involved with IV infusion and injectable therapies, and will not seek indemnification or damages from the indemnified parties.

PrintedName:_____

Signature:_____

Date:_____

Witness:_____

Date:_____

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WRM IV Service Policies

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If you have any questions, please ask us. Please initial each point acknowledging your understanding:

_____ If you are late or miss your appointment, you may be subject to a $50 fee. This will be waived if due to extenuating circumstances on a case by case basis.

_____Services must be paid for at the time of service.

_____Health insurance typically does not cover services provided at Woman Rising Midwifery. If you want to seek insurance reimbursement, we would be happy to provide you itemized invoices that you can submit to your insurance company.

_____I understand that treatments used at Woman Rising Midwifery might not be considered a medical necessity. Treatments rendered are for the purpose of improving your quality of life.

_____ I agree that if I am having any side effects or become sick, that I will follow up with my primary care provider or go to an urgent care or emergency department.

_____I acknowledge that Woman Rising Midwifery and Rebecca Schleuger-Valadao, ARNP CNM are not my primary care provider. I agree that I will continue with routine care through my primary care provider and notify them of treatments prescribed and performed at Woman Rising Midwifery.

_____I understand that there are no refunds for services or products rendered.

_____I understand that having an appointment with Woman Rising Midwifery does not necessarily entitle me to IV infusion or injection procedures. It is at the providers discretion to issue treatment.

_____I am voluntarily requesting treatment with Woman Rising Midwifery and Rebecca Schleuger-Valadao, ARNP CNM in regard to IV infusion therapy and injection therapy as determined by a mutual decision between myself and the medical provider even if it is not considered a medical necessity.

_____I do not hold any medical practitioner of Woman Rising Midwifery responsible for performing age-related preventive care. I agree that I will follow up with my primary care provider to obtain these screenings and I hold Woman Rising Midwifery and Rebecca Schleuger-Valadao, ARNP CNM, harmless if an adverse event occurs during my treatment.

I have read, understand, and agree to all of the above statements.

Print
Name:_____

Signature:_____
__