



Lake Oswego Health Center Consent

for Intravenous (IV) Therapies, Injections, Ozone Therapies, and Other Medical Procedures.

Patient Name (printed) _____

Procedures performed at Lake Oswego Health Center are only as recommended or prescribed by a physician, and the **patient is responsible for fully disclosing any existing health conditions or allergies, as well as any current medications.**

Any procedure that uses needles, anesthesia, and/or an anti-clotting medication may have side effects.

Anesthesia: Anesthesia will be used with Prolozone, trigger point injections, joint injections and neural therapy, using Procaine or Lidocaine as a local, low dose anesthesia. Complications from localized anesthesia can include injury to the surrounding tissues, lingering numbness or tingling at injection site, headache, or nausea. Some patients can have an allergic reaction. **Notify staff if you have had an adverse reaction to anesthesia in the past.**

Anti-clotting medication: Major autohemotherapy and UBI includes the use of a small amount of Heparin to keep blood from clotting. Ozone High Dose Therapy uses a higher dose of Heparin, similar to that used in hospitals to thin blood clots. Complications from Heparin use relate to the effects on the body of thinning the blood. While it is still in the system, external bleeding from cuts or internal bleeding from falls, tumors, or nasal irritation will be more significant than normal. Women may not use Heparin while on their menses. If necessary, there is a drug called Protamine that can reverse these effects. **Notify staff if you have had any injury or fall 3 days prior to any appointment where Heparin is administered.**

Needles: There are general risks associated with the use of needles. These include bruising, swelling or bleeding at the injection site; Pain, including joint pain; Rash; Infection; Injury to surrounding tissues; and in rare cases, stroke, paralysis or death.

Sulfa allergy: Testing for heavy metals can include DMPS or EDTA, which may contain sulfa. **Notify staff if you have a sulfa allergy.**

By signing below, I acknowledge the following:

I have read and understand this consent form.

I have been given the opportunity to ask any questions I have regarding the procedure(s) and I have had those questions answered to my satisfaction.

I have discussed my treatment plan with my doctor, including potential benefits and associated risks. I have disclosed any health conditions, allergies, and/or medications.

I understand the purpose of the prescribed procedure, and also acknowledge that the outcome of my treatment is not guaranteed.

I have been informed of other appropriate treatment choices. Other options include standard of care alternatives, such as prescription medication, physical therapy, or surgery.

I am aware that there may be other risks or complications not discussed that may occur during the procedure.

I voluntarily give my authorization and consent to the performance of the procedure(s) described above.

Patient's Signature:

Date:

Doctor's Signature:

Date:

If the patient is unable to consent his/herself, complete the following:

Patient is unable to consent him/herself because

Legally Responsible Person:

Relationship to Patient:

Date: