

IV Vitamin C Consent

IV VITAMIN C SHOULD NOT BE USED UNTIL THERE HAS BEEN A COMPLETE PRESENTATION OF THE NATURE OF THE PROCEDURE, EXPECTED BENEFITS, MATERIAL RISKS, MATERIAL SIDE EFFECTS, ALTERNATIVE COURSES OF ACTION, LIKELY CONSEQUENCES OF NOT HAVING THE PROCEDURE AND WRITTEN INFORMED CONSENT HAS BEEN OBTAINED.

IMPORTANT INFORMATION AND WARNING

The following points of information, among others, have been presented and made clear and I have had the opportunity to ask any questions concerning this information:

1. I, _____ (name) understand that IV VITAMIN C is administered at a high dose, intravenously, to have its beneficial effects as therapeutic doses cannot be reached through oral supplementation.
2. I understand that the benefits of IV VITAMIN C include treating colds, cancer, influenza, hepatitis, fibromyalgia, chronic fatigue, HIV, genital herpes, shingles, fever blisters and other persistent viral infections. It enhances the benefits of certain chemotherapeutics. Vitamin C prevents hemorrhage and stimulates wound healing. I understand that therapeutic doses cannot be achieved through oral routes but can through IV.
3. I understand that IV VITAMIN C is essentially non-toxic. The risks include hemolysis in G-6-PD deficiency, a risk of tumor necrosis and tumor hemorrhage that can lead to death, reports of kidney failure in those with a history of kidney disease and an increased risk of kidney stones. It is not recommended to be conducted in those with hemochromatosis. I understand that IV vitamin C cannot be given 24 hours prior to and 48 hours after methotrexate chemotherapy.
4. I understand that side effects of IV VITAMIN C include a falsely elevated fasting blood glucose reading within 4 hours of IV vitamin C. Accordingly, people with diabetes should check their blood glucose before starting their IV.
5. I understand as with all IVs and injections there is always the possibility of pain, infection and even death.
6. I understand the alternative courses of action include to do nothing, to continue with current procedures and services, IV turmeric, ozone, oncothermia, IV laser, photodynamic modulation, the use of PEMF devices, surgery, radiation therapy, chemotherapy and pharmaceuticals.
7. I understand the likely consequences of not having IV VITAMIN C include no change in my existing condition, poorer health, a shorter life span and decreased quality of life.
8. I consent to have my file accessed by Dr. Michael Prytula, ND Psc. D, Dr. Mike UM, ND, Psc. D, HBSc. and all staff at Nature Medicine.

I now authorize Dr. Michael Prytula, ND, Psc. D, Dr. Mike Um, ND, Psc. D, HBSc. and the staff at Nature Medicine to start my IV VITAMIN C service OR if my service has already begun with IV VITAMIN C, to continue with it.

CONSENT: _____ Print Name: _____

Name: _____ Date: _____
(Signature)

Address: _____ Telephone Number: _____

STAFF OR DOCTOR'S STATEMENT: I have fully presented to, _____.
The nature and purpose of IV VITAMIN C and the potential risks associated with it. I have asked if he/she has any questions regarding IV VITAMIN C and have answered those questions to the best of my ability.

Staff or Doctor's Signature

Date