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 Ascribe 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, Ascribe 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 Ascribe 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 Ascribe Infusion Therapy. I authorize Ascribe 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 ASCRIBE STAFF MEMBER SIGNATURE **PRINTED NAME** **DATE**

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