Prairie North Health Region

APPENDIX B

Home Care Intravenous Therapy Program Client Consent

I, _____ of _____
(name of client) (address) (phone no.)

consent to Intravenous Therapy as ordered by Dr. _____ or his/her delegate.

Dated this _____ day of _____, 200____.

_____ _____
Signature of Client or Supporter/Guardian Name and Relationship of Supporter/Guardian

_____
Signature of RN obtaining consent

I have received information relating to the therapy prescribed to me and have also received instructions and training from the Home Care Registered Nurse on how to self administer IV Therapy. I understand the therapy prescribed and the instructions, and I am confident I will be able to follow the necessary steps for the safe administration of therapy. I agree to follow all instructions pertaining to my treatment program. I absolve the Prairie North Regional Health Authority of any liability from complications as a result of misuse of the treatment program.

_____ _____
Signature of Client or Supporter/Guardian Date

_____ _____
Name and Relationship of Supporter/Guardian Signature of RN Obtaining Consent