HYDRATE
IV WELLNESS CENTRE

CONTACT INFORMATION

LAST NAME:_____ FIRST NAME:_____ TODAY'S DATE:_____

DATE OF BIRTH:_____ AGE:_____ GENDER: M / F / OTHER

ADDRESS:

_____ _____ _____ _____
STREET CITY PROVINCE POSTAL CODE

PREFERRED PHONE #:_____ EMAIL:_____

OCCUPATION:_____ CARE CARD NUMBER:_____

CAN HYDRATE CONTACT YOU VIA EMAIL? Y / N (PLEASE CIRCLE)

EMERGENCY CONTACT

NAME:_____ PHONE #:_____ RELATIONSHIP:_____

HOW DID YOU HEAR ABOUT US?

☐ WALK-IN ☐ HYDRATE WEBSITE ☐ REFERRAL:_____

☐ NEWSPAPER ☐ SOCIAL MEDIA ☐ OTHER:_____

PLEASE LIST ANY HEALTHCARE PROVIDERS YOU ARE CURRENTLY SEEING

DR._____ SPECIALTY:_____ PHONE:_____

DR._____ SPECIALTY:_____ PHONE:_____

DATE OF LAST DOCTOR'S VISIT:_____ DATE OF LAST BLOOD TESTS:_____

HEALTH HISTORY

WHICH IV/INJECTION ARE YOU INTERESTED IN?_____

PLEASE LIST YOUR MAIN HEALTH CONCERNS IN ORDER OF IMPORTANCE

CONCERN	WHEN IT BEGAN?	SEVERITY 1-10
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

ANY AND ALL MEDICATIONS:_____

1-1015 COOK STREET VICTORIA, BC V8V3Z6
TEL: (250) 590-1482 | FAX: (250) 590-2415
HYDRATEIV.CA | INFO@HYDRATEIV.CA

OFFICIAL MEDICAL DIAGNOSES (NAME, WHEN ITS WAS DIAGNOSED, AND BY WHOM)

DIAGNOSIS	DATE	MEDICAL PROFESSIONAL

ALLERGIES (DRUGS OR FOODS):_____

ARE YOU NERVOUS ABOUT NEEDLES OR HAVE YOU EVER PASSED OUT GIVING BLOOD? ☐ YES ☐ NO

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Benefits of intravenous therapy include:
   - IV substances are not affected by stomach, or intestinal absorption problems.
   - Total amount of infusion is available to the tissues.
   - Nutrients are forced into cells by means of a high concentration gradient.
   - Higher doses of nutrients can be given than possible by mouth without intestinal irritation.
3. Risks of intravenous therapy include but are not limited to:
   - Occasionally to commonly: Discomfort, bruising and pain at the site of injection.
   - Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
   - Extremely Rarely: Severe allergic reaction, anaphylaxis, infection, cardiac arrest.

I have informed the physician of any known **allergies** to drugs or other substances, or of any past **reactions** to anesthetics. I have informed the doctor of all **current medications and supplements**. I am aware that other unforeseeable complications could occur. My signature below confirms that:

1. I understand the information provided on this form and agree to the foregoing.
2. I have informed the physician of a history of:
   a. Kidney failure
   b. Chronic hemochromatosis
   c. Glucose-6-Phosphate Dehydrogenase Deficiency
   d. Red Blood Cell Hemolysis
   e. Liver Disease
   f. Congestive Heart Failure
   g. Legal & Illegal Drug use (eg. Heroin, cocaine, alcohol, etc.)
3. I authorize and consent to the performance of the procedure(s).

My signature on this form affirms that i have given my consent to IV or injection therapy.

I, _____ , have read, understand, and agree to the above policies.
PATIENT NAME

_____ _____
PATIENT SIGNATURE DATE

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