IV Therapy Patient Intake & Safety Screening

MOBILE IV THERAPY & INFUSION PRACTICE PACK

Patient Name / DOB _____

Reason for IV therapy _____

Current medications / supplements _____

Allergies _____

Relevant medical history _____

- ■ Pregnant/breastfeeding
- ■ Heart disease / heart failure
- ■ Fluid restriction
- ■ Known G6PD deficiency
- ■ Active infection / fever
- ■ Kidney disease
- ■ Uncontrolled hypertension
- ■ Bleeding disorder / anticoagulants
- ■ Prior IV reaction
- ■ Other condition requiring clinician review

Vitals / assessment _____

Clinician clearance / modifications _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

General IV Hydration Informed Consent

MOBILE IV THERAPY & INFUSION PRACTICE PACK

I voluntarily consent to peripheral IV hydration and the ingredients documented in my treatment record. Potential risks include discomfort, bruising, bleeding, infiltration, phlebitis, infection, fluid/electrolyte complications, allergic or medication reaction, fainting, and rare serious complications.

I understand IV hydration is not a substitute for emergency evaluation or medically necessary treatment and that benefits or wellness outcomes cannot be guaranteed.

IV solution / additives _____

Indication _____

Alternatives / risks discussed _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

Template notice: General educational/operational starting point only. Customize for the actual patient, treatment, product/device, manufacturer instructions, emergency resources, clinician scope, payer requirements, and applicable federal/state law. Obtain qualified clinical and legal review before use.

Mobile IV Therapy Location & Emergency Readiness Checklist

MOBILE IV THERAPY & INFUSION PRACTICE PACK

- ■ Patient identity verified
- ■ Environment suitable for treatment
- ■ Phone service available
- ■ Baseline vitals obtained
- ■ Emergency supplies checked
- ■ Current physical location documented
- ■ Emergency access/exit available
- ■ Emergency contact documented
- ■ Allergies/medications reviewed
- ■ Escalation/EMS plan reviewed

Treatment location _____

Emergency contact _____

Nearest emergency facility / plan _____

Clinician authorization _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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IV Additive / Medication Administration Record

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Patient / DOB _____

Date / start time _____

Base fluid / volume _____

Additive 1 / dose / lot / expiration _____

Additive 2 / dose / lot / expiration _____

Additive 3 / dose / lot / expiration _____

IV site / catheter _____

Pre-treatment vitals _____

Post-treatment vitals _____

Stop time / disposition _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

IV Complication & Adverse Reaction Record

MOBILE IV THERAPY & INFUSION PRACTICE PACK

- ■ Infiltration / extravasation
- ■ Bleeding / hematoma
- ■ Allergic reaction
- ■ Abnormal vital signs
- ■ Phlebitis
- ■ Syncope / dizziness
- ■ Chest pain / dyspnea
- ■ Other

Time identified _____

Signs/symptoms _____

Immediate actions _____

Medications/interventions _____

Clinician notified _____

EMS / transfer details _____

Outcome / follow-up _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

IV Therapy Aftercare & Warning Signs Acknowledgment

MOBILE IV THERAPY & INFUSION PRACTICE PACK

I received aftercare instructions and understand that persistent bleeding, increasing redness/swelling, severe pain, fever, shortness of breath, chest pain, facial/tongue swelling, fainting, neurologic symptoms, or other severe symptoms require prompt clinical or emergency evaluation.

Specific aftercare instructions _____

Practice contact instructions _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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Injection / IM Wellness Treatment Consent

MOBILE IV THERAPY & INFUSION PRACTICE PACK

I consent to the injection documented in my medical record. Risks may include pain, bruising, bleeding, infection, nerve/tissue injury, allergic reaction, medication-specific adverse effects, and lack of expected benefit.

Medication / ingredient _____

Dose / route / site _____

Indication _____

Risks / alternatives discussed _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____

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Mobile IV Visit Treatment Record

MOBILE IV THERAPY & INFUSION PRACTICE PACK

Patient / DOB _____

Location _____

Arrival / departure time _____

Chief goal _____

Assessment _____

Vitals _____

IV solution / additives _____

IV site _____

Response to treatment _____

Adverse events _____

Discharge condition / instructions _____

Patient/Client Signature: _____ **Date:** _____

Clinician/Staff: _____ **Date:** _____