

Alpine Physicians Health Center
Consent and Authorization for
Iron Dextran Injection

To: _____
Name of Patient

Procedure: Intramuscular Iron Dextran (INFeD) Injection

Physician performing procedure: Dan Carter, ND

1. Alpine Physicians Health Center provides facilities and personnel for the intramuscular injection of iron dextran. You have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until you have had an opportunity to receive such information and to give your informed consent.
 - a. The procedure involves inserting a needle into your gluteal (butt) muscle and injecting the iron dextran described above by your physician.
 - b. Alternatives to iron dextran injections are oral iron preparations.
 - c. Risks of iron dextran injection include:
 - i. Discomfort, bruising and pain at the site of injection.
 - ii. General inflammation may increase temporarily: arthralgia, myalgia, and backache
 - iii. Severe allergic reaction, anaphylaxis, cardiac arrest and death.
 - d. Benefits of intramuscular iron therapy include:
 - i. Injectables are not affected by stomach or intestinal disease; oral iron is poorly absorbed
 - ii. Total amount of infusion is available to the tissues.
 - iii. The dose of iron does not cause intestinal irritation.
2. You have the right to consent to or refuse and proposed treatment at any time prior to its performance. Your signature on this form affirms that you have given your consent to the procedure(s) described above with any different or further procedures which, in the opinion of your physician, may be indicated.
3. The procedure will be performed by or under the direction of the physician named above.

Your signature below means that:

- a. You understand the information provided on this form and agree to the foregoing.
- b. The procedure(s) set forth above has been adequately explained to you by your physician.
- c. You have received all the information and explanation you desire concerning the procedure.
- d. You authorize and consent to the performance of the procedure(s).

DATE: _____ TIME: _____

SIGNATURE: _____
Patient/Representative

If signed by representative, indicate relationship: _____ Date: _____

WITNESS : _____