

Consent and Authorization for Biopuncture Therapy

Patient Name: _____ Primary Practitioner: _____

1. Revivelifelife Clinic provides facilities and personnel to assist your health practitioner in the performance of biopuncture therapy (the injection of nutrients, homeopathics and local anesthetics). You have the right to be informed of the procedure, any feasible alternative options, and the risk and benefits. Except in emergencies, procedures are not performed until you have had to opportunity to receive such information and to give your informed consent.
 - a. The procedure involves inserting a needle into your vein or muscle by injecting the formula described by your health practitioner.
 - b. Please note that some of the formulas may not be approved for injection purposes in Canada while they may be approved in other jurisdictions. These products being used for biopuncture purposes are being done so "off label" in Canada
 - c. Side effects and risks of biopuncture therapy include
 - Discomfort, bruising and pain at the site of injection
 - Inflammation of the vein used for injection, phlebitis
 - General feeling of malaise and fatigue during and just after treatment
 - Reactive hypotension (or rapid drop in blood pressure)
 - Severe allergic reaction, anaphylaxis, cardiac arrest and death
 - d. Benefits of biopuncture therapy include:
 - Injectables are not affected by stomach or intestinal disease
 - Total amount of infusion is available to use by the tissues
 - Nutrients are forced into cells by means of concentration gradient
 - Higher doses of nutrients can be given than possible by mouth without intestinal irritation
 - Biopuncture provides local and systemic effects on a variety of systems depending on the therapeutic being used
2. You have the right to consent or to refuse the 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 your opinion of your health practitioner may be indicated.
3. The procedure will be performed by or under the direction of your Naturopath or Medical Doctor named above with qualified medical assistants.

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 health practitioner
- 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)

Patient Name (print)

Patient Signature

Date