



Dr. Kathleen Allen  
Naturopathic Physician. Midwife. Lactation Consultant.

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**NATUROPATHIC MEDICINE  
INFORMED CONSENT FOR TREATMENT**

I, \_\_\_\_\_, hereby authorize Dr. Kathleen Allen to perform the following specific procedures as necessary to facilitate my diagnosis and treatment or the child's (\_\_\_\_\_) diagnosis and treatment:

**Common diagnostic procedures:** e.g., venipuncture, Pap smears, radiography, laboratory, x-ray.

**Minor office procedures:** e.g., cleaning, dressing a wound, ear lavage, skin scraping, skin cryotherapy.

**Medicinal use of nutrition:** therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

**Botanical medicine:** botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, cremes, plasters, or suppositories.

**Homeopathic medicine:** the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

**Lifestyle counseling and hygiene:** diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

**Vaccination, Psychological Counseling, Contraception, Pharmaceutical prescriptions**

**I recognize the potential risks and benefits of these procedures as described below:**

**Potential risks:** allergic reactions to prescribed herbs and supplements, side effects of medications or vaccinations, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures. Notify Dr. Kathleen Allen if you experience any symptoms which may be secondary to the above procedures.

**Potential benefits:** restoration of health and the body's maximal functional capacity without the use of drugs or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

**Notice to Pregnant Women:** All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr. Kathleen Allen regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my practitioner to the best of his/her ability.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

Original: Chart  
Copy: To patient (if requested)