Irie Natural Center for Health
Dr. Sonya Johnson, NMD

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Consent for B12 Injection, Consent for MIC-B12

Personal Information

Name:_____Date:_____
Address:_____
City:_____State:_____Zip:_____
Phone (home):_____(cell):_____
Email Address:_____
Date of Birth:_____Gender: M / F
Emergency Contact:_____Phone:_____Relationship:_____

Health History

Ongoing Medical Issues:_____
_____
Current Prescription Medications (Include Name of Medication and Dosage): _____
_____
Drug Allergies (Include Name of Drug and Allergic Reaction): _____
_____
Weight Today:_____ Desired Weight:_____

- I UNDERSTAND THE RECOMMENDED DOSE FOR B12 IS 1-2mL INTRAMUSCULAR WEEKLY. (A DOSE OF 1mL MAY BE GIVEN AT THE BEGINNING OF THE WEEK AND A SECOND DOSE OF 1mL AT THE END OF THE WEEK)
- I UNDERSTAND THE RECOMMENDED DOSE FOR MIC-B12-B Complex IS 1-4mL INTRAMUSCULAR WEEKLY.
- POSSIBLE SIDE EFFECTS CAN INCLUDE IRRITATION AT THE SITE, INFECTION, BRUISING, AND TENDERNESS AT THE INJECTION SITE.
- I CERTIFY THAT I DO NOT HAVE AN ALLERGY TO SULFA.
- I CERTIFY THAT I DO NOT HAVE A LIVER OR KIDNEY IMPAIRMENT THAT I AM AWARE OF.

Informed Consent For Treatment

I hereby request and consent to receive medical care by Sonya Johnson, NMD or other medical associates (medical assistants, nurses) who now or in the future may treat me while working at or associated with or serving as back-up for the above named doctor, whether signatories to this form or not. By signing this form, I hereby am giving consent for B12/Mic Injections. In the event an adverse reaction may occur from receiving a B12/Mic Injections, the signature below releases any liability and damages, should this occur, to Sonya Johnson, NMD, and treating staff. Further, this intake form is not a replacement for the clinics Standardized Intake Form which is used for office visit purposes. I have read, or have had read to me, the above information and I consent. I have also had an opportunity to ask questions about the consents content, and by voluntarily signing below I agree to the above-named procedures.

Patient's Name (PRINT)_____

Patient's Signature_____Date_____