LYME DISEASE CONSENT FOR TREATMENT

I _____ (patient) understand that I will be treated for Lyme disease and other tick borne diseases by Dr. Warren Klausner. Treatment often involves the use of antibiotics, antifungals, antiparasitics, antiarthritics, vitamin supplements, herbal formulas, intravenous therapies, a rehabilitation program and possibly other therapies. I understand that some antibiotics and other medications are used for off-label indications. As no single treatment regimen is universally successful it is possible that the antibiotic, antifungal or antiparasitic therapy may be of minimal or no benefit.

I understand that it is conceivable that some or all of my current symptoms may not be due to this illness or they may represent permanent changes in my system, in which case further treatment may be of no further benefit.

There are potentials risks involved in using antibiotics and the other treatments listed above. Some of the more common problems can include but may not be limited to: allergic reactions manifesting as rashes, swelling and difficulty breathing. Such problems may require medications or emergency treatments to reverse the allergy. Other potential complications include stomach and bowel upset including abdominal pain, diarrhea and possible colon inflammation which may require interruption of the Lyme and other tick borne disease medications and the prescribing of other treatments to manage the digestive upset. Secondary infections like yeast of the skin, mouth, intestine and genital tracts may occur resulting in discomfort and the need for corrective therapies. Although unlikely it is possible that the medications used in the treatment may have negative effects on the liver, kidneys and other internal organs.

Because much of the diagnosis, management and clinical conclusions made in my case by Dr. Klausner require my input, such as honest and accurate reporting of all of the symptoms and willingness to agree to ongoing, reasonable testing as requested, I realize that I am therefore a active participant in the diagnosis and therapeutic process and do accept and share responsibility for any and all potential outcomes.

I have discussed the above points with Dr. Klausner and/or his representatives. I understand and accept treatments offered and my role in my care. I also understand that complications may result. With all this in mind I consent to being treated by Dr. Klausner in order to combat the effects of Lyme disease and other co-infections. I understand that reasonable compliance with the regimens is expected and that the staff at Dr. Klausner's office will be contacted by me if any problems arise.

Patient's signature/ _____ Date: _____
legal representative