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***Leech Therapy Patient Consent Form***

I, (Full name) (Date of Birth) \_

Of (address)

hereby agree and consent to the performance of the course of leech therapy treatments.

It was acknowledged to me that the leech therapy is an independent, complementary method of treatment aimed at improving patient’s blood circulation. I understand that bioactive substances injected with the leech’s saliva into human body may help to reduce pain, inflammation and swelling as well as dissolve blood clots, strengthen the immune system, lower cholesterol, assist elimination of toxins leading to the improved functionality of organs and systems. Also, that leech therapy has a relaxing and regenerating effect on the nervous system and may be used alongside other methods of treatment.

I was informed of all contra-indications of the leech therapy procedure including anemia, hemophilia, pregnancy, very low blood pressure, physical exhaustion, previously strong allergic reaction to insect bites, any diagnosed blood disorders, chronic alcoholism, Hepatitis (any variety), HIV /AIDS and any sexually transmitted diseases. I confirm that I do not suffer from any of these contraindications.

I was informed that leech saliva has a strong blood anti-coagulating effect and for this reason should not be used alongside blood-thinning medication (unless in minimal doses). Therefore, I must inform the practitioner if I take any anti-coagulants so that the necessary precautions can be taken by the practitioner to carry out the treatments safely.

I know that the leech bite leaves marks on the skin which usually heal and disappear within few days, weeks or months, but sometimes a small mark, pigmentation or scar may remain permanently, depending on the healing abilities of the patient’s immune system. I accept such possible side effect and agree to the execution of leech therapy procedure.

I know and completely understand that after the procedure some side effects and possible complications may occur such as prolonged and/or excessive post-application bleeding, headache, weakness, high temperature, possible marks, pigmentation or scars left on the skin, redness, bruising, swelling, itching or some individual or allergic reactions. I take full responsibility for any side effects and possible complications and agree that my practitioner Jacina Coyne shall not be liable for any such consequences of the use of medical leeches on me .

I know that there is a potential risk of transmission bacteria from the leeches’ gut. In a rare case of a transfer of bacteria to the patient a course of antibiotics is recommended and I agree to it.

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 ***Signature Date***

I was advised and understand that after leech therapy procedure there is going to be bleeding from the bite area for many hours, typically between 4 and 24. For this reason, I was advised to drink plenty of water and a warm herbal tea, avoid alcohol, smoking, heavy physical exercise and physical work. Drinking lots of water and herbal tea will help to clean toxins and rebuild lost body fluids. I should also avoid (for at least two days) saunas, hot water baths and swimming as hot water may open up the wounds and introduce the infection.

I have been told that after the procedure the bite area will be covered with a sterile cotton wool and a blood absorbing bandage. When the bandage is filled with blood, it should be removed and replaced with a new dressing by the patient. The wound should not be touched and no creams or any products should be applied to it for the first few days to avoid the possibility of infection.

I take responsibility to follow all above-prescribed recommendations.

I agree to provide comprehensive information to practitioner Jacina Coyne about my health history, current health state, main and secondary health complaints and illnesses as I understand this is a necessary information for making the correct diagnosis and treatment plan.

I recognize and agree that complimentary health specialist Jacina Coyne who is carrying out my leech therapy procedures is not responsible for any health damage owing to my own failure to provide all required information about the state of my health or my failure to follow the instructions and advice explained to me verbally together with the one mentioned above.

I was informed and understand, that leeches used in leech therapy treatments come from bio-factories which breed medicinal leeches for sale to therapists, clinics and hospitals, and that leeches are single use only. I confirm that I was informed and agree with disposal methods of used leeches. I understand that at the end of each leech therapy procedure all leeches used on me will be detached from the surface of my skin and disposed in accordance with medical requirements.

I was informed and agree with the purpose of leech therapy, stages of assessment and rules of procedure, also with the existing price structure. I confirm that the information concerning the leech therapy treatment and the post-care procedures were explained to me in clear and concise language that I could understand, and also all relevant terms explained where required.

 I understand that leech therapy and other methods used during treatment are not a substitute for treatment by a medical doctor. I also understand that results are not guaranteed.

By voluntarily signing below I (full name) ……………………………………….………………………, hereby certify that I have read (i) and understood this entire form (ii), have had the opportunity to ask questions (iii) and consented to have leech therapy treatment. I understand that at any given time throughout the treatment I may request the practitioner to stop, modify or change the treatment plan. I can refuse treatment at any time. I agree not to disturb the leeches during the treatment period and will ask for assistance if I have any concern.

I intend this consent form to cover the entire course of treatments to be performed for my present condition and for any other complaints for which I will seek treatment. I have been advised that all medical records and discussions during treatment are strictly confidential. I agree to my special category data related to my health being processed.

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 ***Signature Date***