JOANNE GIGI HARDTKE, ARNP

Last Name:_____First Name: _____ ____Date of Birth: _____

Allergies/Reaction:_____

Phone number _____ Email _____

Ok to text or leave messages at which number:_____YES/NO

Address:_____

Primary Care Doctor:_____Phone:_____

List all Medical Conditions/year diagnosed: _____

Surgeries/hospitalizations Performed/Year_____

Do you smoke?_____ How many packs per day? _____ Caffeine use?____ How much?____

Note amount/frequency of Alcohol consumed?_____ Illicit Drug use ?_____

List any Medications or Supplements you are taking:? Dose/frequency?

_____

_____

Reason for visit:_____When did symptoms start:_____

What have you tried to treat this condition:_____

What imaging tests have been done so far:_____

Does this condition affect your ability to sleep, do chores, exercise, ect_____

Please explain all limitations: _____

Any other symptoms related to this condition:_____

Are you taking any Aspirin, Ibuprofen, Aleve, or other NSAID?

The above is true and I understand that Joanne Gigi Hardtke, ANRP is not my primary care provider but serves to assist with consultation and it is my responsibility to follow up and see a primary care provider for ongoing medical care. I attest that I do not have Medicaid/Medicare.

_____

Signature Print name Date

JOANNE GIGI HARDTKE, ARNP

Informed Consent for Wharton's Jelly Injection

I_____ understand that my provider is recommending Oropro, an umbilical cord therapy (Wharton Jelly) to be injected. Normal Saline is the only additive to the Wharton Jelly tissues being used for my undiagnosed condition. I understand that this therapy is not approved by the Food and Drug Association, (FDA). I also understand that no guarantees or promises have been given to me. I have already seen my primary care provider for my condition and tried recommended FDA options for care.

I understand that the umbilical cord tissues are taken from donated umbilical cords from a healthy mother and healthy live born infant. They are processed at FDA approved lab, Biostem Technologies. I understand that the cells are undifferentiated and contain no blood typing or genetic makeup.

The following area will be treated _____by Joanne Gigi Hardtke, ARNP. Joanne Gigi Hardtke is not my primary care provider and I agree to follow up with my primary provider for ongoing care.

I understand and accept all risks associated with this procedure which may include the following:

Transient hypoglycemia **Infection** **Bruising** **Local swelling**

Discoloration of the injected spot **Allergic reaction**

Headache or light headedness **Possibly no beneficial effect of the treatment**

I understand that this is voluntary. Research has been profusely documented in peer reviewed medical and scientific journals for decades, the therapy is in no way unproven, dangerous, or experimental when administered within the limits and standards of training. I furthermore understand that my participation in this treatment represents a "good faith" effort by the provider. As such, should harm come to me and since I am freely partaking in this treatment, I will hold harmless the provider of this treatment. I understand I am likewise binding that my representatives, estates, successors and assigns hold harmless the provider for this treatment. Since each human body is different the provider makes no warranties or guarantees about these therapies with respect to my condition. I acknowledge that it is my right to cease cellular therapy at any time. Finally, I understand that this procedure is not covered by insurance. I understand that my patient information will be protected. I do not have Medicare/Medicaid. Refunds will not be given for any reason.

With full awareness of the above facts and consideration, I give my consent to administer Wharton Jelly therapy in my best interest.

Witness_____ Date_____

_____

Signature Print name Date