LEECH THERAPY PATIENT CONSENT FORM

Clinic Name: _____ Date: _____
Doctor Name: _____
Patient Name: _____

Consent to Undergo Leech Therapy

I, the undersigned, hereby consent to undergo Leech Therapy as part of my Ayurvedic treatment at the above-mentioned clinic. I understand that this procedure involves the application of medicinal leeches to specific areas of my body to promote therapeutic benefits.

Acknowledgment of Information

1. **Therapy Purpose:**
   I understand that Leech Therapy (Jalaukavacharana) is a detoxification procedure aimed at improving blood circulation, reducing inflammation, and treating various health conditions.

2. **Procedure and Potential Benefits:**
   I have been informed about the procedure, its potential benefits (e.g., pain relief, improved circulation, and toxin removal), and its role in maintaining overall wellness.

3. **Possible Risks and Side Effects:**
   I am aware of possible side effects, such as mild bleeding, itching, temporary swelling, or minor infections, and understand that these are generally rare and manageable.

4. **Precautions Taken:**
   I have disclosed all relevant medical information, including any allergies, bleeding disorders, or other health concerns, to the attending doctor.

5. **Voluntary Participation:**
   I confirm that I am undergoing Leech Therapy voluntarily and understand that I may discontinue the session at any time.

Declaration

By signing below, I acknowledge that I have read and understood the information provided about the Leech Therapy. I have had the opportunity to ask questions, and my concerns have been addressed to my satisfaction. I consent to receive the therapy under the care of the attending doctor at the above-mentioned clinic.

Patient Signature: _____
Date: _____
Doctor Signature: _____
Date: _____

Witness (if applicable): _____
Date: _____