Consent for the Treatment of Chronic Babesiosis, Bartonellosis, and/or Lyme Disease

Please discuss any questions with Dr. Lindner before initialing each statement and signing.

_____ I am seeing Dr. Lindner for the diagnosis and treatment of chronic babesiosis, bartonellosis, and/or Lyme disease. I do not hold him responsible to diagnose or treat other diseases or to provide acute or preventative medical care. I will consult my primary care provider (PCP) or specialists for such services.

_____ I understand that chronic infections with these organisms are not recognized by the Centers for Disease Control (CDC) or the Infectious Diseases Society of America (IDSA) and that Dr. Lindner's practice is based upon his own experience, his interpretation of the human and veterinary literature, and upon patients' responses to therapy.

_____ I understand that these infections are often not detectable by commercially available tests. Diagnosis is based ultimately upon clinical judgment and response to treatment.

_____ I understand that the treatment of these infections can be difficult, requiring many months or years of multiple prescription medications and non-prescription supplements. My condition will worsen before it improves.

_____ I understand that Dr. Lindner will prescribe some medications that are not FDA-approved for this infection, and/or at doses and durations that are not FDA-approved for any indication.

_____ I understand that, without insurance coverage, the out-of-pocket cost for the most effective doses of medications and supplements could be as much as $800/month at the highest doses. If insurance covers the prescription medications, the cost may be as low as $300/month.

_____ I understand that there are risks and possible complications involved in attempting to eliminate these parasites: increased inflammation and suffering, fever, hemolysis, headaches, nausea, anxiety, depression, suicidality, derealization, impaired cognition, rashes, enlargement of the spleen, liver and/or kidney dysfunction, and blood clots in the legs. If I have any severe psychiatric or physical symptoms, I will inform Dr. Lindner and will see my PCP or go to an emergency room.

_____ I agree to report my responses to treatment, including adverse effects, to Dr. Lindner as requested, to monitor my urine and pulse oximetry, and get lab tests as requested.

_____ I understand that Dr. Lindner may recommend corticosteroid/DHEA therapy to control inflammation and allow me to tolerate therapy. High steroid doses can cause muscle loss, bone density loss and possible fracture, infections, and elevated blood sugar and blood pressure.

_____ I hereby consent to the administration of antimicrobials, medications and supplements by Dr. Lindner for the purpose of reducing and hopefully eliminating these parasites, improving my quality of life, and maintaining my health as well as possible in the process.

_____Date_____

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