



Informed Consent for Appetite Suppressants

I. Procedure and Alternatives:

1. I, _____ (*patient or patient's guardian*) authorize The medical team at IM&P Wellness Center to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling

. "As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses.

"Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects (as noted below)."

"As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants use in this manner may give."

3. I understand it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight any significant medical problems that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this weight loss. In particular, a balanced calorie counting program or an exchange eating program without the use of the appetite suppressant would likely prove successful if followed, even though I would probably be hungrier without the appetite suppressants.

continued



Informed Consent for Appetite Suppressants continued...

II. Risks of Proposed Treatment:

I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated in the labeling involves some risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and heart irregularities. Less common, but more serious, risks are primary pulmonary hypertension and valvular heart disease. These and other possible risks could, on occasion, be serious or fatal.

III. Risks Associated with Being Overweight or Obese:

I am aware that there are certain risks associated with remaining overweight or obese. Among them are tendencies to high blood pressure, to diabetes, to heart attack and heart disease, and to arthritis of the joints, hips, knees and feet. I understand these risks may be modest if I am not very much overweight but that these risks can go up significantly the more overweight I am.

IV. No Guarantees:

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

V. Patient signature. Do not sign until you have had your questions answered:

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants.

DATE: _____ TIME: _____

PATIENT: _____

WITNESS: _____

Congratulations on taking that all important step to loose weight. Our team at **IM&P Wellness Center** are sensitive to your struggles with weight and appetite control. We are here to help you succeed. We will cheer you on and comfort you on this life changing journey. Weight Management is a life long journey and we are here to help you.

A. Initial Visit

Your initial visit will consist of a complete history and physical exam to asses your mental and physical status before starting the program. Labs required : Complete blood count (CBC) Comprehensive metabolic panel (CMP) Lipid Panel Thyroid function TSH w/ Reflex to T4. Within the past month. 12- lead Within the last 3 mths.

B. Week One

You week 1 appointment will include a Resting Metabolic Rate (RMR) analysis . You are advised to complete the RMR sheet prior to your appointment. Please remember to fast for 4 hour prior to this appointment.

C. Follow-Up Visits

1. Clinic hours are from 10 am to 6 pm
2. Weekly when you come in for clinic you will check in with the receptionist.
3. You will be given a Products Order form.
4. Once you complete it return the form to the receptionist.
5. Product payment will be due at this time.
6. You can then have a seat in the waiting room.
7. The Medical Assistant will call you in to obtain your weight, B/P and pulse.
8. If you are due for any lab work or a visit with your physician the Medical Assistant will take you to the exam room or draw your lab.
9. You will then proceed to check out after your visit where your products will be waiting for you.