3519 Town Center Boulevard Suite B Sugar Land, Tx. 77479
281-277-3300

CONSENT TO TREATMENT FOR BIO-IDENTICAL HORMONES

I hereby give my consent for evaluation & treatment of peri – menopause, menopause, andropause, thyroid disorders, adrenal fatigue, stress & other hormonal imbalances by the administration of Bio – Identical (iso-molecular) hormones replacement therapy & any nutritional supplements including minerals, vitamins, anti-oxidants, & medicines designed to modify hormone levels.

I understand that the nature & purpose of treatment is considered medically unnecessary or experimental & not currently indicated treatments. The risks involved & the possibility of complications have been explained to me.

Although in the physicians' opinion the majority of data points toward safety, no one has yet proven or has yet disproved the casual relationship between the use of bio-identical hormone therapy & cancer. The risk of cancer has not been studied by bio-identical hormones. I understand that careful surveillance & close monitoring are requirements of all patients to minimize any possible risk.

I understand there are other studies that point to a higher incidence of cancer in patients who take hormone replacement therapy. However, studies like these, show an association (two variables present simultaneously), fail to demonstrate cause & effect. The Cancer Association risk is not well studied & no data is available.

Smoking is associated with increased risk of complications with hormone therapy. The other potential risk of hormones includes blood clots, thrombo-embolic disorders including pulmonary embolus, hypertension, stroke, & other complications that are associated with synthetic hormones.

Testosterone cream or gel is used in men for low testosterone levels with symptoms that include tiredness, weakness, osteoporosis, truncal obesity & sexual dysfunction orders. Synthetic forms of testosterone are also available. Risk factors are the same for any hormone replacement. The casual relationship of testosterone hormone with prostate is very unclear. Patients with prostate cancer are recommended to get a replacement therapy. Blood tests prior to the treatment are essential & repeat laboratory evaluation is done every 3-6 months. We recommend annual examinations with your primary physician.

I understand that no guarantee has been made to me regarding outcomes neither of this treatment nor on resolution of my symptoms. I understand that not all patients receive the same degree of response. I also understand that pregnant women cannot take hormones & its not the purpose of the treatment to prevent pregnancy.

I also understand that compounded hormones are neither approved nor disapproved by the FDA.

All questions I have regarding this treatment have been answered to my satisfaction. I understand that I will be responsible for administering the hormones prescribed to me. I will confirm & comply with the recommended dose & methods of administration. I also agree to conform to the request of all tests, as required to monitor my hormone levels. I understand that failure on my part to follow my physicians' laboratory testing, mammograms, bone density, colonoscopy & any other necessary recommended tests at intervals established by my physician & failure to follow up with my physician at recommended appointments may lead to adverse side effects. I understand that this is a specialized practice & does not hospitalize patients. I also understand that I will continue under the care of my other physician (s) such as Internist & Gynecologist for Well Woman Exam & any on going medical condition as well as for any medical consultation that I may need. I agree to provide the physician with a copy of all my recent lab results & other tests including mammogram, colonoscopy, etc. Failure to provide annual mammogram results may result from the non negligent administration of the proposed treatment. I also understand that this is a purely elective treatment voluntarily agreed upon by me.

I further consent to the utilization of the results of my progress in any research study performed by my physician & my name will not be used & every effort will be made to protect my privacy.

To attest to my consent to this treatment, I hereby affix my signature to this authorization to treatment.

Patient's Name:	**Physician's Name:**
Signature of Patient:	**Physician's Signature:**
Date:	**Date:**