INFORMED CONSENT FOR USE OF APPETITE SUPPRESSANTS

Patient’s Name: ____________________________ Date: ____________________________

I authorize Dr. ____________ to treat me so that I can lose and maintain a healthy weight.

I understand that my treatment may involve, but not limited to, the use of appetite suppressant in patients with normal weight, for more than 12 weeks and in higher or lower doses than stated in the appetite suppressant labeling.

I understand that the use of the appetite suppressants in patients with BMI less than 27, for more than 12 weeks and higher doses than stated in the appetite suppressant labeling involves some risks. The more common risks include: nervousness, sleeplessness, headache, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat and heart irregularities. Less common, but more serious and fatal risks include primary pulmonary hypertension and valvular heart disease.

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

I understand that continuing me on appetite suppressants will depend on my progress in weight loss and weight maintenance.

I understand that there are other ways and programs that can assist me to lose weight and maintain a healthy weight. I understand that a balanced calorie counting program or an exchange-eating program without the use of the appetite suppressant would likely prove successful if followed.

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 want to be successful.

I have discussed with Dr. ____________ various treatment options and feel adequately informed concerning the risks associated with the proposed treatment.

I have read and fully understand this consent form.

Patient Signature: ____________________________