

**PHENTERMINE WEIGHT LOSS PROGRAM**

**INFORMED CONSENT**

I request the use of Phentermine, along with strict dietary restrictions for the purpose of weight loss. I understand that as part of the program, I will be given a limited physical, orientation to the program with supporting materials and I will be instructed on how to administer Phentermine myself. I understand that initial blood tests may be necessary to rule out any conditions that would disqualify me from the program. I understand there is no guarantee for the effectiveness of Phentermine.

Prior to my treatment, I have fully disclosed any medical conditions or diseases such as history of gallbladder disease, diabetes, autoimmune diseases, HIV, heart disease, liver disease, kidney disease, uncontrolled high blood pressure, seizure disorders, blood disorders (anemia, thalassemia, hemophilia, etc.) emphysema or asthma, and any history of stroke or cancer. These contraindications have been fully discussed with me. Further contraindications are outlined below. If I fail to disclose any medical condition that I have, I release the doctor and facility from any liability associated with this procedure.

Initials:

# Contraindications and Warnings

\*\*\***Patients with the following should not use Phentermine:**

1. An allergy to Phentermine
2. Those who have taken a Monoamine Oxidase Inhibitor (MAOI) within the last 14 days
3. History of Advanced Arteriosclerosis, Cardiovascular Disease, moderate to severe Hypertension, (Including elevated blood pressure without diagnosis greater to or equal to 140/90), Hyperthyroidism, or Glaucoma
4. Currently in an agitated state or have a history of drug or alcohol abuse
5. Women who are nursing, pregnant, or plan on becoming pregnant

**Patients with the following should take special precautions and consult their doctor before using Phentermine:**

1. Allergies to medicines, foods, or other substances
2. Those who have diabetes and may require a larger dose of insulin while taking Phentermine
3. Have a brain or spinal cord disorder, Atherosclerosis, Advanced Hypertension, Diabetes, or high cholesterol or lipid levels

**Side Effects**

While Phentermine is generally free of negative side effects, there is the possibility of the following:

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| --- | --- | --- |
| • Dry mouth | • Diarrhea | • Nausea/Vomiting |
| • Unpleasant taste | • Constipation | • Fatigue |
| • Heartburn | • Stomach Pain | • Increased Heart Rate |
| • Skin Rash or Itching | • Lactic acidosis | • Insomnia or Restlessness |
|  |  |  |

Less common side effects include:

* Convulsions (Seizures) • Erectile Dysfunction • Depression
* Panic attacks • Fever • Hallucinations
* Tremors or shaking • Fainting • Overactive reflexes

**I understand Phentermine treatments may involve these risks and other unknown risks:**

I understand that use of Phentermine is absolutely contraindicated during pregnancy and breastfeeding. I understand that it is my responsibility to inform the provider if I am pregnant, if I am trying to become pregnant, or if I become pregnant during the course of these treatments. Initials:

I agree to immediately report any problems that might occur to my medical provider during the treatment program. I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release the doctor and facility from any liability arising as a result of this. Initials: : \_\_\_

I understand that I may quit the program at any time. While adverse side effects or complications are not expected, in the event that an illness does occur, I understand that I need to contact the office immediately and report to provider. If I experience an emergency situation, I understand that I need to go to an emergency facility. Initials:

I understand that if there are any changes in my medical history, including elevated blood pressure greater or equal to 140/90, I will not be considered a candidate for Phentermine. I also understand if there are any changes in my medications or any other changes relevant to this procedure, I will advise the provider at that time. Initials: \_\_\_\_\_\_\_\_\_

I have read and fully understand the above terms. All my questions have been addressed to my satisfaction. I agree to release the doctor and the facility from any liability associated with this procedure. In the event a dispute arises over the outcome of the procedure, I consent solely to arbitration as a legal means of settlement.

Patient’s Name Printed:

Patient’s Name Signed: Date:

Provider’s Name Printed:

Provider’s Name Signed: Date: