	Affix Patient Label
	Patient Name: DOB:

CONSENT FOR THE USE OF ANTI-OBESITY CONTROL MEDICINES

This information is given to you so you can make an informed decision about taking **Anti-Obesity Medicines.**

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE YOUR PROVIDER(S) AT BRONSON BARIATRIC AND METABOLIC SPECIALISTS WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICINES, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICINE USAGE SHOULD YOU AND YOUR BARIATRIC PROVIDER DECIDE UPON THEIR USAGE.

Reason and Purpose for using Anti-Obesity Control Medicines

- Help with weight loss

Benefits of using Anti-Obesity Control Medicines

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Achieve weight loss around 5-10% of current bodyweight in one year
- Improve the control of diabetes
- Improve the control of high blood pressure
- Improve cholesterol

Risks of Anti-Obesity Control Medicines

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect. The side effect depends on the type of medicine. If you experience these side effects we will consider stopping the medicine. You may need supportive treatment. For example, if you experience constipation, we may increase the fluid and fiber intake, etc. Your doctor will discuss these treatments with you.

- Palpitations
- Nervousness
- Dry mouth
- Constipation
- Insomnia
- Headaches
- Dizziness
- Fatigue
- Nausea and/or vomiting

Weight loss is not recommended in pregnancy. These medicines should not be used by pregnant women. They can cause harm to a developing baby.

Risks Specific to You

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Alternative Treatments

- Continue to work on nutrition, physical activity and behavior modification.
- Weight loss surgery.
- Do nothing. You can decide not to have the medicine.

If you choose not to have this treatment

- You may still lose weight if you continue to work on nutrition, physical activity and behavior modification.

General Information

- Many anti-obesity medicines are considered "controlled medicines." By law, a controlled medicine can only be prescribed from one office at a time.
- I agree that only **BRONSON BARIATRIC AND METABOLIC SPECIALISTS** will prescribe anti-obesity medicines for me.
- I agree that it is my responsibility to tell **all** my doctor(s) about all medicines prescribed to me.
- **I understand that the use of anti-obesity medicines is not recommended for people with certain medical histories, allergies, or other medicine use**. I agree that I will be honest in telling my doctor(s) of any changes to my medical history or medicines. I understand that not doing this can be dangerous to my health.
- I agree to take the medicine only as prescribed and directed by my Bariatric Provider. Taking this medicine in any other way could affect my health and be dangerous.
- I understand that the lowest effective dosage will be tried before increasing dosages.
- I agree to use only one pharmacy to fill this prescription. BRONSON BARIATRIC AND METABOLIC SPECIALISTS will tell area pharmacies of the terms of this agreement. If I need to go to a different pharmacy I will ask my Bariatric Provider.
- I will not share, sell, or trade my medicine with anyone. I understand that doing so is illegal. If I do this my doctor may stop seeing me as a patient.
- I understand that the use of some of anti-obesity medicines longer than 12 weeks is considered "off label." This means it is not approved by the Food and Drug Administration for longer use. I understand that my doctor(s) are experienced specialist(s) in obesity medicine. The doctor may decide to use the medicine for longer periods of time if it could help my treatment.
- I agree to tell my doctor about any side effects or adverse reactions to the medicine.
- I understand that the purpose of medicines for weight loss is to be used with a program that includes nutrition, physical activity and/or behavior modification.
- I agree that my doctor(s) may change the dose of my medicine or stop it. This is done to check its effect on my weight loss, hunger and health.
- I understand that much of the success of the program will depend on my efforts. There are **NO GUARANTEES** in medical treatment in the disease of obesity. I also understand that I will have to keep monitoring my weight after I lose weight.

By signing this form I agree

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to begin using **Anti-Obesity Control Medicines**.

Patient Signature: ____Date:__________Time:________

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: ____Date:___________Time:________
Interpreter (if applicable)

For Provider Use ONLY

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to use Anti-Obesity medicines.

Provider signature: ____ Date: ____________Time: ___________

Teach Back

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to use Anti-Obesity medicines.

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment____
____ Area(s) of the body that will be affected: ____
____ Benefit(s) of the medication: ____
____ Risk(s) of the medication: ____
____ Alternative(s) to the medication: ____

OR

____ Patient elects not to proceed: ___________________________________ Date: __________ Time: ________
(patient signature)

Validated/Witness: ____ Date: _________ Time: _________