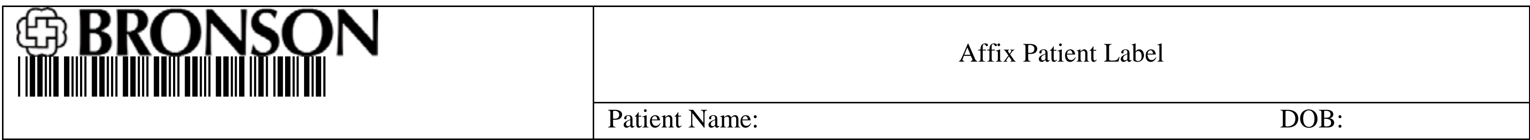
Affix Patient Label

Patient Name: DOB:

Informed Consent Bronson Weight Management Program

This information is given to you so you can make an informed decision about participating in the **Bronson Weight Management Program.**

Reason and Purpose of the Program

This program is to help you in your weight loss efforts. This program may consist of a low calorie diet, a regular exercise program, and instruction on ways to change your behavior. It may involve the use of anti-obesity medicines. Other treatment options may include a very low-calorie diet or a protein-supplemented diet. If medicines are used, they have been tested and found to be safe and effective.

Benefits of this Program

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.

- Weight loss
- Improvement in overall health

Risks of participating in the Bronson Weight Management Program

Any medical treatment may involve risks as well as benefits. There is health risks associated with having excess weight or obesity. Risks of this program may include but are not limited to:

- Nervousness
- Difficulty sleeping
- Headaches
- Electrolyte abnormalities
- Dry mouth
- Gastrointestinal disturbances
- Weakness
- Fatigue
- Pancreatitis
- Psychological problems
- Gallstones
- High blood pressure
- Rapid or slowing of the heartbeat and heart irregularities
- Risk of weight regain

Your doctor and your dietitian will be following you closely to watch for these side effects. They will also be monitoring your labs if needed. If you do experience any of the above mentioned risks, you may need additional testing such as imaging studies, heart monitoring or hospitalization.

Risks Specific to You

____

____

Alternative Treatments

- Do nothing. You can decide not to participate in the program.

If you choose not to have this treatment

Risks associated with being overweight are high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints, including hips, knees, feet and back, sleep apnea, and sudden death. These risks may be low if you are not significantly overweight but will increase with additional weight gain over time.

General Information

Much of the success of the program will depend on your efforts. There are no guarantees the program will be successful. Obesity is a chronic, lifelong condition that will require changes in eating habits and permanent changes in behavior to be treated successfully.

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 participate in the Bronson Weight Management Program

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 program: ____

____ Risk(s) of the program: ____

____ Alternative(s) to the program: ____

OR

____ Patient elects not to proceed: ________________________________ Date: __________ Time: __________

(patient signature)

Validated/Witness: ____ Date: ___________Time:_________