BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Bariatric Exercise Program

This information is given to you so that you can make an informed decision about participating in the Bariatric Exercise Program.

Reason and Purpose of the Program:

This is a prescribed exercise program. It can help with weight loss and health and well-being. It is recommended as a part of dietary counseling and stress management.

Benefits of this program:

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

- Weight loss
- Increase in body strength
- Greater ability to move

Risks of an exercise program:

No exercise program is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

Every effort will be made to lessen risks. Staff will assess your condition before each session and supervise your exercise.

You are responsible to decrease or stop exercise and tell the staff if you have any symptoms.

- Abnormal blood pressure
- Fainting or dizziness
- Shortness of breath
- Weakness
- Confusion
- Chest pain
- Heart rhythm changes (palpitations)
- Heart attack
- Stroke
- Death
- Risk of bodily injury including, but not limited to:
  - Injuries to the muscles, ligaments, tendons, and joints of the body.
  - Injuries as a result of a fall. This may include cuts, teeth injuries, head injuries or bone fractures.

Risks associated with smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

_____

_____

_____

_____

Alternative Treatments:

Other choices:

- Do nothing. You can decide not to participate.
- Your dietician can discuss other treatments for weight loss with you.

If you choose not to participate in this program:

- You may have more difficulty losing weight.

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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 dietician. My questions have been answered.
- I want to participate in: **Bronson Bariatric Exercise Program**.
- I understand that other personnel, including the Sports Performance Trainer, or Certified Athletic Trainers, may assist with this program. The tasks will be based on their skill level.

Patient Signature_____Date:_____Time:_____

Relationship: ☐Patient/Parent of minor ☐Closest relative (relationship) ☐Guardian/POA Healthcare

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 the patient has agreed to procedure.

Dietitian/Sports Performance Trainer

Signature: _____ Date: _____ Time: _____

Teach Back

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

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date:_____ Time:_____

(Patient signature)

Validated/Witness: _____ Date: _____ Time:_____