

## Informed Consent for Estrogen/Progesterone Replacement Therapy

PATIENT NAME: \_\_\_\_\_

Although Estrogen/Progesterone Replacement Therapy has been utilized safely and effectively, it is necessary to discuss potential risks. You should also be aware of the alternatives to Estrogen/Progesterone replacement therapy, including not receiving the treatment. It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weigh your options or consult another health care provider. Please review the following items, which discuss informed consent. Your clinical provider will attempt to answer all of your questions to your satisfaction. Initial beside each statement that you have read, understand, and agree with:

\_\_\_\_\_ This is my consent for **Treasure Coast Primary Care**, including any physician or nurse who works with the company, to begin treatment for Estrogen/Progesterone Replacement Therapy.

**Estrogen Therapy:** Bio-identical estrogens are available in various forms including oral capsules, troches, patches, pellets and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g. – from blood clots or cancer) and mood swings. High potency conjugated estrogens (e.g. – Premarin) have been associated with increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole area of estrogen replacement is undergoing further evaluation. **DO NOT** take estrogen if you have breast cancer.

**Progesterone Therapy:** Bio-identical progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.

\_\_\_\_\_ **I understand it is my responsibility to be aware of the above complications and let my practitioner know when I have a concern.**

\_\_\_\_\_ I have had an opportunity to discuss with **Treasure Coast Primary Care** and its medical practitioners my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits, and alternatives have been answered. I am satisfied with the answers.

All of my questions and concerns regarding treatment have been answered to my satisfaction. I further acknowledge that the risk and benefits of this treatment have been explained to me. I am of sound mind, under no undue influence and am competent to make this decision and do so of my own free will. I have no further questions. I consent to taking Estrogen/Progesterone as proposed by my clinical provider. I have complete understanding of and agree to follow the terms of this Informed Consent. A copy of this document has been given to me.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date