TREASURE COAST Primary Care

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Informed Consent for Testosterone Replacement Therapy

PATIENT NAME: _____

Although Testosterone Replacement Therapy has been utilized safely and effectively, it is necessary to discuss potential risks. You should also be aware of the alternatives to testosterone 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:

_____1. This is my consent for **Treasure Coast Primary Care**, including any physician or nurse who works with the company, to begin treatment for Testosterone Replacement Therapy.

_____2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as gynecomastia, acne, fat loss, and increased estrogens.

_____3. I understand I may retain extra fluid in the body – This can cause problems for patients with heart, kidney, or liver disease.

_____4. TRT may cause your LH and FSH levels to be severely limited, affecting your fertility. Patients should not be on TRT if attempting to father a child.

_____5. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.

_____6. TRT may contribute to increased cardiovascular risk, including heart attack or stroke. I will report any symptoms of chest pain, shortness of breath, slurred speech or weakness in one part or one side of my body. TRT can make sleep apnea worse. TRT can increase my risk for blood clots.

_____7. **I understand it is my responsibility to be aware of the above complications and let my practitioner know when I have a concern.**

_____8. I understand that I will have periodic blood tests to monitor my blood levels.

_____9. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse.

_____10. 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.

_____11. I agree to have my personal clinical provider perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels, and a comprehensive metabolic panel.

_____12. I agree that TRT works best when I change lifestyle habits such as limiting alcohol, stopping smoking, exercising, and eating correctly.

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 not further questions.
I consent to taking Testosterone 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