# Physician's Weight Control and Wellness Centers

***Patient Informed Consent for Appetite Suppressants and Participation in a Weight Management Program***

1. I, _____(patient or patient's guardian) authorize the Physician's Weight Control and Wellness Centers physicians and assistants to assist me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program and instruction in behavior modification techniques. Other treatment options may include a variety of other diet approaches depending on the needs of the individual patient. I understand that treatment options may involve the use of appetite suppressant medications and other supplements. My treatment may necessitate the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the dose indicated in the appetite suppressant labeling.

2. I have read and understand my doctor's statements that follow:

   "Medications, including the appetite suppressants, have labeling worked out between the makers of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to 12 weeks) using the dosages indicated in the labeling."

   "As a bariatric physician, I have found the appetite suppressants helpful for periods far in excess of 12 weeks, and at times in larger doses than those suggested in the labeling. As a physician, I am not required to use the medication as the labeling suggests, but I do use the labeling as a source of information along with my own experience, the experience of my colleagues, recent longer term studies and recommendations of university based investigators. Based on these, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses. In this office, an appetite suppressant may be used in combination with another appetite suppressant drug and other supplements."

   "As a bariatric physician, I believe the possibility of side effects as explained to me is outweighed by the benefit of the appetite suppressant use for longer periods of time and when indicated in increased doses. However, you must decide if you are willing to accept the risks of side effects for the possible help the appetite suppressants used in this manner may give."

3. I understand that if I develop side effects from the diet or the medication, I will discontinue the diet and/or the medication(s) and notify the medical staff of the Physician's Weight Control and Wellness Centers as soon as possible. I also understand that if the problem is worrisome or severe, I will go to the nearest Emergency Room or see my primary medical doctor as soon as possible. (take your medications with you)

**Patient's Consent:**
I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form and in talking with my doctor regarding risks associated with the proposed treatment and regarding other treatments not involving the appetite suppressants. This signed consent will remain current unless I notify the Physician's Weight Control and Wellness Center otherwise.

**DATE:**_____ **TIME:**_____

**PATIENT:**_____ **WITNESS:**_____

**Physician Declaration:**
I have explained the contents of this document to the patient and have answered all the patient's related questions, and, to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

_____

**Physician's Signature**