Larry K. Parker, MD
Anti-Aging Program

CONSENT FOR TESTOSTERONE REPLACEMENT THERAPY

I, _____ the undersigned, request to be prescribed, by Dr. Larry Parker, Testosterone as a treatment of my medical condition.

- I understand that this prescription for Testosterone is indicated either for the treatment of Androgen Deficiency of the Aging Male (ADAM), sometimes called Andropause or Hypogonadism, or Testosterone Deficiency, based upon my medical history, physical findings and laboratory tests.
- I understand that Larry K. Parker, MD, cannot guarantee any positive results or that there will be no side effects or harm. The goal and potential benefit of this therapy is to prevent, reduce or control the symptomatic dysfunction that occurs as a result of testosterone deficiency or the aging process and the low testosterone production that occurs in aging males.
- I understand that the conventional medical community and many Medical Doctors believe that Testosterone supplementation is contra-indicated in a patient with past history of prostate cancer and/or prostatic hypertrophy (BPH). I have been fully informed, and I am totally satisfied with my understanding that this proposed treatment may be viewed by the conventional medical community as new, controversial or detrimental, and unnecessary by the Food and Drug Administration, given the present state of knowledge regarding the human aging process.
- While a study published in the New England Journal of Medicine, January 2004, reviewed 72 medical studies and found no evidence that testosterone therapy causes prostate cancer, I understand that questions have been raised about Testosterone as a cause of prostate cancer, since it is an anabolic hormone and can increase the growth rate of cancer cells.
- I understand that side effects may occur with the use of Testosterone. Possible side effects may include oily skin, acne, moodiness, irritability, slight bruising at the injection site, increased hematocrit, exacerbation of sleep apnea, alteration of lipid profile, increased blood pressure, and insulin resistance. I agree to cease using the testosterone and contact my provider and if necessary, seek immediate medical attention, in the event I knowingly develop any adverse side effects.
- I understand that the use of exogenous testosterone may result in a mild to moderate testicular atrophy and a lowered sperm count, and that my ability to father children may be lessened.
- I understand the importance of maintaining a healthy lifestyle with the use of Testosterone, and agree to continue with a recommended program of healthful nutrition, regular exercise, stress management and nutritional supplementation with the use of Testosterone. I further agree to continue any other hormone replacement therapies recommended by my physician.
- I understand that careful monitoring is crucial with Testosterone replacement therapy and agree to comply with the following monitoring recommendations while receiving Testosterone replacement therapy:
    1. Total and Free Testosterone levels, PSA, CBC, estradoil, fasting glucose, fasting insulin and hemoglobin A1C are measured initially, then 8-10 weeks after initial replacement and are repeated every 6 months thereafter.
    2. PSA is measured every 6 months in men over the age of 40.
    3. Other hormone levels may be monitored, as well as other blood tests appropriate for treatment.
    4. Assessment for physical side effects 4-8 weeks after initial replacement and every 2-6 months thereafter.
    5. Monitoring intervals may change at the discretion of the physician.

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6. Annually: Physical examination, baseline blood testing, baseline prostate exams.

1. I understand the potential risks and contraindications associated with the use of Testosterone Replacement Therapy, and that the alternative is to leave the hormone levels as they are and do nothing.
2. I certify that I have read the above consent and fully understand it. I believe I have adequate knowledge upon which to base information consent. I fully understand what I am signing and hereby request and consent to treatment using supplemental exogenous Testosterone.

_____ _____
Patient Signature Date

_____ _____
Dr. Larry K. Parker / Physician Assistant Signature Date

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