# CONSENT FOR HORMONE IMPLANTATION

I,_____authorize _____

a designated Physician or Practitioner to perform the following operations or procedure.

**STERILE SURGICAL PLACEMENT OF HORMONE PELLETS UNDER THE SKIN**
I understand the reason for the procedure is: Hormone Replacement Therapy (Estradiol and or Testosterone)
RISKS; Risks of the particular procedure include: Bleeding and/or infection. Bleeding and/or infection as well as a 2%-4% possibility of rejection and/or extrusion of 1 or more pellets. I understand that _____ is not responsible for rejection/extrusion or any pellets after insertion.

**LOCAL ANESTHESIA:** The administration of anesthesia also involves risks, most importantly a rare risk of reaction to medication causing death. I consent to the use of such anesthetics as may be considered necessary by the physician responsible for these services.
I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

**PATIENT'S CONSENT:** I have read and fully understand this consent form and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.
I am aware that these charges could be non-covered by my insurance and any remaining are my responsibility.

PATIENT SIGNATURE:_____ DATE:_____

**PROVIDER'S DECLARATION:** I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

PROVIDER'S SIGNATURE: _____ DATE:_____

# PROSTATE EXAM WAIVER
# FOR TESTOSTERONE PELLET THERAPY

I, _____voluntarily choose to undergo implantation of subdermal Bio-Equivalent Testosterone Pellet Therapy.

For today's appointment:

☐ It is my decision to NOT have a prostate exam

**OR**

☐ I have had a prostate exam on (date) _____by M.D._____

I have voluntarily chosen to sign this release form. I agree that if any issues arise and/or develop while on pellet therapy, I release _____ from any liability.

PATIENT SIGNATURE:_____DATE: _____

# MALE TESTOSTERONE
# ACKNOWLEDGEMENT INSERTION FORM

Although this therapy has been approved for human use, there are few doctors who currently administer testosterone pellets in the United States. I realize that this is not the usual and customary means of prescribing testosterone. I realize that the advantages of testosterone for men include: a) behavioral changes including decreasing depression, decreasing anxiety and irritability, increasing energy and motivation, stabilizing moods, allowing one to cope better, improving one's self-image and self-worth, and enhancing one's stamina; b) improvement in one's cognitive function so one is no longer operating "in a fog", improving short-term memory and allowing one to stay focused to complete a task; c) physical effects such as decreasing total body fat, increasing lean body mass, increasing muscle mass, and increasing bone mass; and d) sexual benefits such as increasing libido, increasing early morning erections, increasing firmness, and duration of erections.

I realize there are potential concerns with testosterone therapy and they include the possibility of enhancing a current prostate cancer to grow more rapidly. For this reason, a rectal exam and prostate specific antigen blood test is to be done before starting testosterone and will be conducted each year thereafter. If there is any question about possible prostate cancer, I consent to a follow-up with an ultrasound of the prostate gland.

I realize in the past, male athletes have abused testosterone. When they took huge quantities of synthetic testosterone, they may have incurred heart problems and elevated cholesterol. However, low dose, non-oral, natural testosterone that is used in Bio-Identical hormonal therapy has not been associated with these problems.

The second concern we have with testosterone therapy is that it may increase one's hemoglobin and hematocrit, or thicken one's blood. This can be reversed through donating blood periodically. This problem can be diagnosed with a blood test. Thus, a complete blood count should be done at least annually.

The final major concern we would have, especially in younger men, is the testosterone administration can suppress the development of sperm and the sperm count could dramatically reduce while a person is on testosterone therapy. However, to date, this appears to be in the majority of men a reversible process, once the testosterone is discontinued, the sperm count is restored, usually in 3-6 months. This is extremely important in younger men taking testosterone therapy. In this early stage, we have encouraged them to produce samples and have them frozen, just in case there is any permanent long term effect in their situation- We have encouraged any men who are concerned about their fertility in the future to have a semen analysis prior to initiation of testosterone therapy. Currently, testosterone administration is not to be used as a form of male contraception.

My signature certifies that I have read the above and acknowledge I have been encouraged to ask any questions regarding Bio-Identical hormonal therapy. Individual results may vary.

PATIENT SIGNATURE:_____ DATE:_____