PATIENT INFORMED CONSENT FOR APPETITE SUPPRESSANTS

I. PROCEDURE AND ALTERNATIVES

1. I, _____________________________________, (patient or legal guardian) authorize D.S. Salter, M.D. and Why Weight, LLC to assist me in my weight reduction efforts. I understand my treatment my involve, but is not limited to, the use of appetite suppressants for more than 12 weeks and when indicated in higher doses than the recommended doses on the labels.

2. I have read and understand the following statements made by my doctor:

   “Medications, including the appetite suppressants, have labeling worked out between the maker 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 physician, I have found the appetite suppressants helpful for period 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. Base on these, I have chosen, when indicated, to use appetite suppressants for longer periods of time and, at times, in increased doses.

   “Such usage has not been systematically studied as that suggested in the labeling and it is possible, as with most other medications, that there could be serious side effects. (As noted in II below).

   “As a bariatric physician, I believe the probability of such side effects is outweighed by the benefit of the appetite suppressant use for longer periods of time, and when indicated, in the increased doses. However, you must decide if you are willing to accept the risk of side effects, even if they might be serious, for the possible help the appetite suppressants used in this manner may give.”

3. I understand that it is my responsibility to follow the instructions carefully and to report to the doctor treating me for my weight, any significant medical problem(s) that I think may be related to my weight control program as soon as reasonably possible.

4. I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressants will be dependent on my progress in weight reduction and weight maintenance.

5. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and to maintain this loss. In particular, a balanced calorie-counting program or an exchange-eating program without the use of appetite suppressants would likely prove successful if followed even though I would probably be hungrier without the appetite suppressants.
II. RISKS OF PROPOSED TREATMENT

1. I understand this authorization is given with the knowledge that the use of the appetite suppressants for more than 12 weeks and in higher doses than the dose indicated on the labeling involves some increased risks and hazards. The more common risks include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or fatal.

III. RISKS ASSOCIATED WITH BEING OVERWEIGHT OR OBESE

1. I am aware that there are certain risks associated with remaining overweight or obese. Among them are the tendencies towards high blood pressure, diabetes, heart attack and heart disease, and arthritis of the joints to include hips, knees and feet. I understand these risks may be modest if I am slightly overweight, but that these risks can increase significantly as my weight increases.

IV. NO GUARANTEES

1. I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight for the remainder of my lifetime in order to be successful.

V. PATIENT’S CONSENT

1. 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 were not 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 treatment not involving appetite suppressants.

NOTICE TO ALL PATIENTS.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING OTHER POSSIBLE TREATMENTS, ASK DR. SALTER PRIOR TO SIGNING THIS CONSENT FORM.

*****DO NOT SIGN THIS INFORMED CONSENT UNTIL YOU HAVE SPOKEN WITH DR. SALTER.*****

Patient’s Signature: __________________________________________ Date: __________________________

PHYSICIAN’S DECLARATION

I have encouraged the patient to ask any questions she/he may have regarding the content of this form and have answered all questions. To the best of my knowledge, I feel the patient is informed adequately concerning the benefits and risks associated with the use of appetite suppressants, the benefits and risks associated with alternative therapies, and the risks of continuing in an overweight state. After adequate information, the patient has consented to therapy involving appetite suppressants in the manner indicated above.

Physician’s Signature: _______________________________ Date: _______________ CO Lic. #: ___________________