ELPIS HEALTHCARE

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CONSENT FOR USE OF COMPOUNDED AND BRAND-NAME WEIGHT LOSS MEDICATIONS

Patient Name: _____**Date of Birth**: _____

Phone Number: _____ **Email Address**: _____

Purpose of Treatment
You are being offered compounded or brand-name weight loss medications to aid in weight management. This form outlines the risks and benefits, and your consent to proceed with the prescribed medications.

Type of Medications:
1. Compound Medications: Custom-Prepared by a licensed pharmacy to meet your specific needs.
2. Brand-Name Medication: FDA Approved, Commercially available weight-loss medications.

Potential Benefits:
- Weight loss and body fat reduction
- Improved health conditions (e.g., type 2 diabetes, hypertension)
- Increased energy and physical activity

Possible Risks and Side-Effects:
- **Compounded Medications**: May have unknown side effects due to customization.
- **Brand-Name Medications**: Common side effects may include nausea, dizziness, headaches, and gastrointestinal issues. Serious side effects could include heart complications or allergic reactions.

Special Considerations:
- **Allergies**: Inform your provider of any known allergies.
- **Pre-existing Conditions**: Discuss any heart disease, hypertension, or other chronic conditions with your provider.
- **Long-Term Use**: Ongoing monitoring may be necessary, especially for long-term treatment.

CONSENT:
I understand the benefits and risks associated with the use of compounded and brand-name weight loss medications. I consent to the use of these medications as part of my weight management plan and agree to follow the prescribed regimen. I understand that I can withdraw consent at any time and will notify my provider of any side effects or concerns.

Patient's Name: _____**Signature**: _____**Date**: _____

Provider's Name: _____**Signature**: _____**Date**: _____