

WEIGHT LOSS PROGRAM CONSENT FORM

I, _____, authorize Judi Goldstone, MD and her assistants, to help me in my weight reduction efforts. I understand that my weight loss program may consist of a balanced diet, regular exercise, instruction in behavior modification, and the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. I have been advised and understand that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the package insert and product literature. I agree to tell Dr. Goldstone about any concerns I have about any weight loss medications and will continue to consult with her until my questions are satisfactorily answer and my concerns are put to rest.

I understand that any medical treatment may involve risks as well as proposed benefits. Risks of the weight loss program Dr. Goldstone may prescribe for me include but are not limited to: nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal.

I also understand that certain risks are associated with remaining overweight or obese. Risks associated with remaining overweight include but are not limited to: tendencies to high blood pressure, diabetes, heart attack, heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but

that they increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior in order to be treated successfully.

I realize that I should not sign this consent form unless all the subjects addressed in the form have been adequately explained to me.

If you have any questions regarding the risks and hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other treatments, ask Dr. Goldstone now before signing this consent form.

By signing this document I attest and agree that I have read and fully understand this consent form and its subject matter, that my questions have been answered to my complete satisfaction, acknowledge that I have been urged to ask any questions I have, and that I have been given adequate time to read this consent form.

Date & Time: _____ Patient: _____