

CONSENT FOR USE OF ANTI-OBESITY CONTROLLED MEDICATIONS

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT THE WEIGHT REDUCTION CLINIC AT LAKE STREET FAMILY PHYSICIANS WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND DR. HAGENSWEIECICKI OR ELIZABETH WERNER PA-C DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Some anti-obesity medications are considered “controlled medications.” By law, a controlled medication can only be prescribed from one facility at a time; therefore, I agree that only Lake Street Family Physicians will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my provider(s) at Lake Street Family Physicians and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity medications is contraindicated with certain medical histories, allergies, or other medication use.** I agree that I will be honest in disclosing this information and will notify my provider(s) at Lake Street Family Physicians of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by the prescribing provider at Lake Street Family Physicians. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered “off label” or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) at Lake Street Family Physicians are experienced specialist(s) in obesity medicine who will, at times, elect or choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at Lake Street Family Physicians.

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: _____ Date: _____

Patient Name (printed): _____