TIER 1
HEALTH AND WELLNESS
Tier1HW.com

Keith Nichols, MD
Angie Nichols, RN

P: 423-417-1700 | 931-520-0200 F: 866-719-8717
2700 Oak St. Chattanooga, TN. 37404

CONSENT FOR FEMALE HORMONE SUPPLEMENTATION THERAPY

I request and consent to the administration of hormone(s) and oral supplements and authorize that these will be prescribed by Dr. Keith Nichols of Tier 1 Health and Wellness. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed to me _____ (Patient to Initial). I understand that I will be responsible for administering the hormones and supplements prescribed to me, and I will conform and comply with the recommended doses and methods of administration _____ (Patient to Initial). In addition, I understand that no early refills of testosterone will be allowed due to loss, theft, not following prescribed dose, or for any other reason in compliance with federal law of the **Controlled Substances Act** _____ (Patient to Initial).

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report any adverse reaction or problems that might be related to hormone therapy to Tier 1 Health and Wellness. I understand that there are possible risks and complications if I do not comply with the recommended dosages. I understand that the role of Tier 1 Health and Wellness is for hormone supplementation only and agree that I will be under the care of another physician for all other medical conditions. Tier 1 Health and Wellness is not a substitute for my family physician, internist, OB/GYN, or other healthcare provider. I agree that I will have an annual physical exam or wellness check performed prior to beginning hormone replacement therapy and annually thereafter as a condition of remaining a patient of Tier 1 Health and Wellness _____ (Patient to Initial). Furthermore, I understand that I am responsible for providing documentation of my annual exam and/or mammogram to Tier1 Health and Wellness _____ (Patient to Initial).

Although not anticipated, there are risks associated with the use of HRT. The following adverse effects have occurred with some androgens and may occur with testosterone but are not limited to endometrial hyperplasia, clitoral enlargement, decreased breast size, breast tenderness, cramping, bloating, irritability, deepening of the voice, increased muscle mass, alteration of the menstrual cycle, increased facial and body hair growth, hirsutism, increased or decreased libido, male pattern baldness, oily skin, pruritus, acne, nausea, headache, anxiety, amnesia, depression, generalized paresthesia, asthenia, emotional lability, hostility, insomnia, hypertension, nervousness, dyspnea, decreased blood glucose and/or alteration of the insulin requirement for diabetic patients, alteration of the lipid profile, retention of water sodium, potassium, calcium, and inorganic phosphates, increase the fluid retention effect of corticosteroids, cholestatic jaundice, alterations in liver function tests, hepatic neoplasms, peliosis hepatis, cholestatic hepatitis, jaundice, sleep apnea, suppression of clotting factors II, V, VII, and X, alteration of prothrombin time, bleeding in patients on concomitant anticoagulant therapy, polycythemia, increased hemoglobin and hematocrit, hypersensitivity (including skin manifestations and anaphylactoid reactions), venous thromboembolism, DVT (blood clot), and alteration of special senses: rare cases of central serous chorioretinopathy (CSCR). I acknowledge and accept these risks along with any other unforeseen adverse reaction or risk _____ (Patient to Initial).

Testosterone is a **Schedule III** controlled medication that falls under the **Controlled Substances Act**. I understand that the FDA has issued a black box warning stating that testosterone may increase the risk of blood clots, heart attack, and stroke and has shown potential for abuse and substance dependency. I acknowledge and accept these risks _____ (Patient to Initial).

The risks of testosterone have been fully explained to me as well as alternative treatment options. I have been counseled on lifestyle modifications and other non-pharmacological methods to potentially increase my testosterone naturally. I have been given the opportunity to ask questions, and fully understand and accept all risks involved with testosterone administration _____ (Patient to Initial).

I fully understand that I am being prescribed testosterone by Dr. Nichols off label to treat my symptoms _____ (Patient to Initial).

I have read and understand all the above agreement. I understand that this therapy is elective, and my participation is my quality of life choice. Verbal and printed information has been provided to me regarding the benefits and risks associated with hormone supplementation therapy. My questions and concerns have been addressed to my satisfaction, and I hereby request and consent to treatment using hormone supplementation therapy.

Patient Signature:_____ Date:_____