TIER 1
HEALTH AND WELLNESS
Tier1HW.com

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CONSENT FOR MALE HORMONE SUPPLEMENTATION THERAPY

I request and consent to the administration of hormone 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.

I understand that I will be responsible for administering these hormones and supplementations prescribed to me, and I will conform and comply with the recommended doses and methods of administration.

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 & 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 & Wellness is not a substitute for my family physician, internist, urologist, 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 _____(Initial).
Furthermore, I understand that I am responsible for providing documentation of my annual exam &/or mammogram (women) to Tier1 Health & Wellness. _____ (Patient to initial)

Although not anticipated, there are risks associated with the use of HRT. The following adverse reactions in the males have occurred with some androgens and may occur but are not limited to:Enlargement of breasts, Gynecomastia, and excessive frequency and duration of penile erections, increased facial and body hair growth, male pattern of baldness, oily skin, acne myocardial infarction stroke, retention of sodium, chloride, water, potassium, calcium, and inorganic phosphates.Nausea, cholestatic jaundice, alterations in liver function tests, rarely hepatocellular neoplasms and peliosis hepatis Suppression of clotting factors II, V, VII, and X, bleeding in patients on concomitant anticoagulant therapy, and polycythemia.Increased hemoglobin and hematocrit. Increased or decreased libido, headache, anxiety, depression, and generalized paresthesia.Hypersensitivity, including skin manifestations and anaphylactoid reactions.Venous thromboembolism, DVT (blood clot). Special senses: Rare cases of central serous chorioretinopathy (CSCR). Inflammation and pain at the site of intramuscular injection. Drug abuse/Addiction Testosterone is a Schedule III controlled substance in 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, stroke, and addiction. I acknowledge and accept these risks._____.

Decreased sperm count, testicular atrophy, irreversible infertility. I have been offered the use of HCG and/or Clomid to decrease these risks and I accept_____ decline _____ the use of both/either to preserve fertility and/or testicular atrophy_____.

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_____.

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 of 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:_____