PATIENT NAME:_____

THE MEN'S CLINIC - MADISON
WWW.THEMANTHING.COM
MADISON, MS

CONSENT FOR TESTOSTERONE REPLACEMENT THERAPY

A FEW THINGS TO KNOW ABOUT TESTOSTERONE REPLACEMENT THERAPY

It is important to understand that medicine is an inexact science. Although we will carry out your treatment carefully, results can vary in their degree of success. It is quite natural for a patient undergoing Testosterone Replacement Therapy to want to know that everything will turn out all right. Most of the time it will be fine, however it is necessary to discuss potential risks.

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It is important that you consider the information we have provided you. Be sure that you are doing what is right for you. If you are unsure, then perhaps you should take some time to weigh your options or consult another health care provider.

Please review the following, which discusses informed consent. Any questions that you may have should be brought to our attention. Your clinical provider will attempt to answer all of your questions to your satisfaction.

Directions: Initial beside each statement that you have read, understand, and agree.

___1. This is my consent for The Men's Clinic - Madison, including any physician or associated staff who works with the company, to begin treatment for Testosterone Replacement Therapy.
___2. It has been explained to me, and I fully understand, that occasionally there are complications with this treatment such as Acne, Breast Enlargement, Mood Swings, as well as the following (#3 - #7):
___3. Extra fluid in the body – This can cause problems for patients with heart, kidney, or liver disease.
___4. Sleep disturbance – This is called sleep apnea and is more likely to occur with patients who have lung disease or are overweight.
___5. Prostate enlargement - This may cause problems with urinating.
___6. Changes in cholesterol levels, red blood cell levels, PSA levels, liver function enzymes, and other hormone levels which will be monitored with periodic blood tests.
___7. I understand that I will have periodic blood tests to monitor my blood levels.
___8. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse.
___9. I have had an opportunity to discuss with The Men's Clinic - Madison and its associated staff my complete past medical and health history including any serious problems and/or injuries. All of my questions concerning the risks, benefits, and alternatives have been answered. I am satisfied with the answers.
___10. I understand that the exam by The Men's Clinic - Madison does NOT replace a full physical exam by a personal physician.
___11. I agree to have my personal physician perform a yearly full physical exam including a digital rectal exam. If I do not have a personal physician, The Men's Clinic - Madison will assist in locating one for me.

PATIENT NAME:_____ **DATE:**_____

WITNESS:_____ **DATE:**_____