

Consent for Testosterone Replacement/hCG Therapy/No Other Therapy Agreement

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. While most of the time this is the case, it is very important for you to be aware of the potential risks, as well as the benefits, expected from the treatment when deciding on whether to begin Testosterone Replacement Therapy. You should also be aware of the alternatives to testosterone replacement therapy, including not receiving the treatment. 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 discuss 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 with.

1. This is my consent for Sheffrin Men's Health, including any physician or nurse who works with the company, to begin treatment for Testosterone Replacement Therapy. **Initials** _____
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 (a-d): **Initials** _____
 - a. Extra fluid in the body – This can cause problems for patients with heart, kidney, or liver disease.
 - b. Sleep disturbance – This is called sleep apnea and is more likely to occur with patients who have lung disease or are overweight.
 - c. Prostate enlargement - this may cause problems with urinating.
 - d. 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.
3. I understand that I will have periodic blood tests to monitor my blood levels. **Initials** _____
4. I understand there is no guarantee as to the result and that if I stop treatment, my condition may return or get worse. **Initials** _____
5. I have had an opportunity to discuss with Sheffrin Men's Health and its medical practitioners 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. **Initials** _____
6. I understand that the physical exam by Sheffrin Men's Health does NOT replace a full physical exam by a personal physician. **Initials** _____
7. I agree to have my personal physician perform a yearly full physical exam including a digital rectal exam, lipid profile, cholesterol levels, and a comprehensive metabolic panel. If I do not have a personal physician, Sheffrin Men's Health will assist in locating one for me. **Initials** _____
8. I understand that prolonged TRT therapy may reduce ejaculate volume and reduce sperm count, possibly affecting fertility. **Initials** _____
9. I understand that there may be an increased chance of hair loss or thinning. **Initials** _____

Our comprehensive, standardized treatment protocol allows us to use lowest effective dose to minimize side effects and maximize benefits of TRT for all patients while maintaining strict safety measures. Our general approach to all patients and especially ones with history of cardiovascular disease and/or advanced age is to make sure they are first appropriate candidates for therapy, to make sure the patient understands all the risks and benefits involved in TRT, and to proceed with caution and adjust dosing as needed, depending on the individual risk factors.

I agree that, while a patient of Sheffrin Men's Health, I will not take any type of anabolic steroids, testosterone gels, hormone "boosters," pro-hormones or any additional testosterone supplementation not provided by Sheffrin Men's Health during my treatment plan. At any time, if use of these items is discovered, I understand I may be discharged as a patient of Sheffrin Men's Health. **Initials** _____

Patient Name (PRINT) _____

SIGNATURE _____ DATE _____