HORMONE SUPPLEMENTATION THERAPY CONSENT FORM

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by the Health Care Provider. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy prescribed for me.

INITIAL _____

I understand that I will be in charge of injection/administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration prescribed by the Health Care Provider.

INITIAL _____

I understand that the initial blood tests will be performed to establish my baseline hormone levels. I agree to report to the Health Care Providers and any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

INITIAL _____

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for prevention purposes is a new and controversial specialty and there are no guarantees with respect to the treatment prescribed.

INITIAL _____

I understand that the role of the Health Care Provider is for hormone replacement **ONLY**. I agree that I am and will be under the care of another Health Care Provider for all other medical conditions including all preventative medical care (i.e. Pap smear, Mammogram, Colonoscopy, Bone Mineral Density, Immunizations, Prostate Screening, other medication refills, etc.)

INITIAL _____

I have been informed that some insurance companies and OHIP do not pay for hormone supplementation therapy. I therefore agree to pay for all services, including any additional laboratory testing and pharmacy charges myself, with the understanding that I will not be reimbursed by my insurance company.

INITIAL _____

I have read and understand all of the above consent. I have been provided with ample time to answer all of my questions before signing this consent. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and herby request and consent to the treatment using hormone supplementation therapy.

INITIAL _____

CONTROLLED SUBSTANCE
Agreement & Informed Consent

The goal of this treatment is for the management of my condition, in order to live a more productive and active life. I realize that I may have a chronic illness, and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to manage (but probably not eliminate) my condition so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s) my treatment plan will be tailored specifically for me.

I UNDERSTAND that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat my condition may be controversial because of the uncertainty regarding the extent to which they provide long-term risks of non–treatment and drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give informed consent.

Controlled Substance Agreement:

The following agreements are made between the Patient and Health Care Provider, as identified above, and outlines the duties and expectations of each party and will be considered a binding agreement. This agreement will be part of the patient's medical records.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. This Controlled Substance Agreement, relates to my use of any all medication(s) to manage my condition, as prescribed by my Health Care Provider.
2. All medication(s) and prescriptions for the treatment of my condition will be obtained from only my Health Care Provider.
3. My Health Care Provider will provide medication(s) for the management of my condition, so long as I follow the rules, terms, and conditions specified in this agreement. Failure to comply with any of the rules, terms, and/or conditions of this agreement may result in discontinuation of the medication(s) and / or may discharge from Health Care Provider's care and treatment.
4. All mediation(s) prescribed by my Health Care Provider must be obtained at only (1) pharmacy. I will provide my pharmacist with a copy of this agreement, at the request of my Health Care Provider.
5. I will use the medication(s) exactly as directed by my Health Care Provider.
6. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be changed or discontinued.
7. My Health Care Provider may at any time choose to discontinue the medication(s) for the treatment of my condition.
8. I will disclose to my doctor all other medication(s) that I take at any time, prescribed by any doctor other than my Health Care Provider.
9. I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition, since the use of other medication(s) may cause harm.
10. I will stop all other medication(s) for the management of my condition unless otherwise directed by my Health Care Provider.
11. I will not share, sell or otherwise permit others, including my family and friends to have access to my medication(s).
12. I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse/diversion of my medication(s); nor will I give or sell them to anyone else. Lost or stolen medication(s) and/or prescriptions may not be replaced.

13. I agree not to obtain or seek any other medication(s) that are in the same class prescribed by my Health Care Provider from any other source (including Emergency Department, 'Walk – in – Clinic,' etc. or illicitly) without first contacting my Health Care Provider. If I have been receiving other medication(s) prescribed by other doctors that has not been approved by my Health Care Provider, this may lead to a discontinuation of the medication(s) and treatment.
14. I understand that the Province of Ontario tracks information provided by pharmacies regarding all controlled substance prescriptions. My Health Care Provider may access this data at any time, if there is a concern that I may be violating this Controlled Substance Agreement.
15. I will notify my Health Care Provider's office during office hours at least fourteen (14) business days in advance before running out of medication(s) so the appropriate refills can be made.
16. I understand that refills will **NOT** be ordered before the scheduled refill date, even if my medication(s) runs out. When travelling, arrangements may be made in advance of planned departure date.
17. If it appears to my Health Care Provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), my Health Care Provider may try alternative medication(s) or may taper me of all medication(s). I will not hold my Health Care Provider liable for problems caused by the discontinuance of the medication(s).
18. I recognize that my condition represents a complex problem that may benefit from other therapies (i.e. psychotherapy, alternative medical care, etc.). I also recognize that my active participation in the management of my condition is extremely important. I agree to actively participate in all aspects of the management program recommended by my Health Care Provider to achieve increased function and improved quality of life.
19. I hereby give my Health Care Provider permission to discuss all diagnostic and treatment details with my other Health Care Provider(s) and pharmacist(s) regarding my use of other medication(s) prescribed by other doctor(s).
20. I must keep all follow–up appointments as recommended by my Health Care Provider or treatment and/or medication(s) may be discontinued.
21. **I acknowledge that non-compliance to the route and frequency of administration of the medication(s) will lead to immediate discharge and dismissal from my Health Care Provider's care.**

INITAL _____

22. **I recognize that obtaining any other controlled substances illicitly will lead to immediate discharge and dismissal from my Health Care Provider's care.**

INITAL _____

By signing, I _____ *agree to the conditions listed above.*
Printed Full Name

_____ _____
Signature **Date**

PREFERRED PHARMACY

Name: _____

Location: _____

I certify and agree to the following:

1. I am reading and signing this informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgement.
2. I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of non – treatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this Controlled Substance Agreement. All of my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.
3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.
4. I agree to the use of the medication(s) in the treatment of my condition and to the terms of this informed consent and Controlled Substance Agreement.

Patient/Other Legally Responsible Person:

_____ _____

Signature **Date**

Witness/Health Care Provider:

_____ _____

Signature **Date**