**Male Testosterone Hormone Consent Form**

**General:**

Bio-Identical Hormone pellets are comprised of naturally derived concentrated hormones. The hormones are designed to be biologically identical to the hormones a man albeit decreasingly due to age. Bio-identical hormones have the same effects on the body as one's own hormones.

**Benefits and Risks**:

Advantages of testosterone therapy for men include:

a) decreasing depression, anxiety and irritability, increasing energy and motivation, stabilizing moods - allowing better coping, improving one's self-image and self-worth and enhancing stamina;

b) improving cognitive function/no longer operating "in a fog", improving short-term memory and focus;

c) physical effects such as decreasing total body fat, increasing lean body mass, muscle mass and bone mass;

d) sexual benefits such as increasing libido e.g. early morning erections, possibly increasing firmness and duration of erections (Viagra or Cialis may be used concomitantly).

The above benefits do come with risks. Very high dose use of *synthetic* testosterone has been associated with serious risks, complications and side effects including liver and heart problems as well as increases in cholesterol. **However, low-dose, non-oral, natural testosterone used in pellet therapy has not been associated with these problems**.

There is some risk, even with natural testosterone therapy, of enhancing an *existing* current prostate cancer to grow more rapidly. For this reason, **a rectal exam and prostate specific antigen (PSA) blood test is to be completed before starting testosterone and every 12 months thereafter**. If there are any questions about possible cancer, an ultrasound of the prostate gland may be required as well as a referral to a qualified specialist. *You may be asked to sign a PSA and/or rectal exam waiver if you fail to have these yearly.*

While urinary symptoms typically improve with testosterone, there is the possibility symptoms may worsen before improving.

Testosterone therapy may thicken blood by increasing the concentration of red blood cells. Symptoms may include headaches and dizziness. It may be associated with an elevation in blood pressure. This condition is called *secondar*y *polycythemia.* Thus, a complete blood count (CBC) or hematocrit (HCT) should be done annually. This condition can be completely reversed by lowering subsequent testosterone doses and/or with therapeutic blood draws.

Testosterone replacement can suppress the development of sperm and the sperm count. This is especially concerning for young men. However, to date, in a majority of men, this appears to be a reversible process once testosterone is discontinued. There is the possibility semen production will decrease while on hormone therapy. If this becomes a concern, the testosterone dose can be decreased or treatment can be discontinued. Once treatment is discontinued, semen production should return to normal. Any men concerned about future fertility should have a semen analysis prior to initiation of testosterone therapy. Currently, testosterone is not to be used as a form of male contraception.

Additionally, it is not unusual for testicular size to decrease while on testosterone therapy. This condition can be reversed with discontinuation of therapy.

**Pellet Insertion:**

Sterile surgical placement of testosterone pellets under the skin is performed by a designated medical professional (Physician or Physician Assistant). Insertion of pellets requires the use of local anesthesia consisting of 1% lidocaine and epinephrine. A brief burning sensation is common when the anesthesia is injected. Epinephrine can cause temporary shakiness, jitteriness and increased heart rate.

**Insertion Risks**:

As with any form of implant, there is always a risk of infection, bruising or bleeding at the insertion site. We have found men returning to a vigorous exercise program 2-5 days after insertion have a higher risk of pellet extrusion or working themselves out of the skin. We have also found infection at the insertion site and/or pellet extrusion can occur when the insertion site is continually rubbed or irritated by the pant waistline or belt. Instructions on the post-pellet insertion sheet must be followed to avoid such risks.

**Labs and Appointments:**

I understand **lab work** is required prior to my first appointment and if not available, then the appointment will be postponed. I also understand labs are necessary for management of my hormone replacement, especially during the initial 6-8 months of therapy. Labs are required prior to the initial insertion, 4 weeks after the initial insertion, and 2 weeks prior to each maintenance insertion. Once my hormone levels are stable, labs will be drawn on a yearly basis. Additional labs may be drawn when deemed necessary by the treating provider or when requested by you, the patient. I understand I am responsible for any lab charges not covered by my insurance company.

**Charges:**

I understand fees include the provider fee, insertion fee and testosterone pellet fee. The pellet fee varies and depends on the number of pellets I may receive. The precise amount is determined by the treating medical provider.

**Payments**:

I understand payment is due in full at the time of service. **I understand the clinic does not accept insurance.**

***I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge the risks and benefits of this treatment have been explained to me and I have been informed of complications, including one or more of those listed above. I accept these risks and benefits and I consent to the insertion of hormone pellets under my skin.*** ***I understand no guarantee or assurance has been made as to the results of the procedure or that it may not cure any condition I may have.***

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_