POLO
HEALTH + LONGEVITY CENTRE

CONSENT FORM FOR BIO-IDENTICAL HORMONE REPLACEMENT (BHRT)

PATIENT CONSENT FORM FOR BIO-IDENTICAL (NATURAL) HORMONE REPLACEMNT THERAPY (BHRT) AND TESTOSTERONE THERAPY (MALE/ FEMALE PATIENTS) AND THYROID REPLACEMENT THERAPY.

Dr. _____ has discussed the following combination of Integrative Medicine, Bio-Identical Hormone Replacement Therapy (BHRT) & Testosterone Therapy with me: **(patient's initials _____)**

TREATMENT

The Treatment is called Integrative Medicine which includes: Bio- Identical (Natural) Hormone Replacement Therapy. The physician will sometimes suggest supplements & vitamins for the patient. **(patient's initials _____)**

HORMONE REPLACEMENT THERAPY

Dr. _____ and I have discussed using Integrative Medicine which can be a combination of Bio-Identical Hormone Replacement Therapy which is used to treat pms, peri-menopause, menopause (women), other female hormone imbalances & Testosterone Therapy in men for andropause and other male hormonal imbalances.

My physician has also reviewed the cardiovascular risks associated with testosterone replacement therapy.

If you have any questions concerning the proposed treatment, ask your physician now before signing this consent form.

My physician has reviewed the issues surrounding risk of breast and/or prostate cancer and the use of hormones. They have reviewed the Women's Health Initiative trial and E3N Cohort studies findings with me if appropriate. I have had the opportunity to ask questions and have them answered to my satisfaction.

I agree that it is my responsibility to keep my mammogram and breast exams or PSA and prostate exams up to date through my family physician's office: **(patient's initials _____)**

PATIENT'S CONSENT

I have read and fully understand this consent form and realize my Bio-Identical Hormone Replacement Treatment, Testosterone Therapy, Hormone Lab Tests, Prescriptions, Supplements & Vitamins and the physicians time and consultations with me, plus my future consultations are all fee based & I agree to pay the fee at the time of my session.

PATIENT'S CONSENT FOR THYROID REPLACEMENT THERAPY

I understand that **Dr.** _____has recommended treatment with thyroid medications for symptoms of low thyroid and/or anti aging treatment. I understand that my thyroid tests may not be diagnostic for thyroid dysfunction by traditional medical guidelines. Risks of this treatment regimen have been explained to me by my physician. I have had the opportunity to ask questions and have them answered to my satisfaction. **(patient's initials _____)**

I give my consent to the administration of the above named BHRT treatment, testosterone therapy, integrative medicine and lab tests as needed.

DATE_____

PATIENTS SIGNATURE FOR CONSENT _____

PATIENTS NAME (print please) _____

PHYSICIANS SIGNATURE _____