ALASKA PREMIER HEALTH

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Patient Informed Consent
Concerning Medications
on the Alaska Premier Health Program

1.0 Procedure and Alternatives

1.1 I, _____(patient or guardian), authorize the Medical Providers at ALASKA PREMIER HEALTH to assist me in my weight reduction efforts. I understand my treatment may involve, but not be limited to; the use of appetite suppressants for more than twelve weeks, and the use of appetite suppressants in higher doses than the dose indicated on the appetite suppressant's labeling. I understand that I may meet the criteria for surgical management of obesity. If I want to pursue surgical management my healthcare provider will provide a referral.

1.2 I have read and understand my medical provider's statements that follow:

"Medications, including the appetite suppressants, have labeling worked out between the maker of the medication and the Food and Drug Administration. This labeling contains, among other things, suggestions for using the medication. The appetite suppressant labeling suggestions are generally based on shorter term studies (up to twelve weeks) using the dosages indicated in the labeling."

"As a Bariatric medical provider, I have found the appetite suppressants helpful for periods far in excess of twelve weeks, and at times, in larger doses than those suggested in the labeling. As a medical provider, I am not required to use the medication as the labeling suggests. I do use the labeling as a source of information, along with my own knowledge and experience, the results of recent longer term studies, and recommendations of university based investigators. Thus, I have chosen, when indicated, to use the appetite suppressants for longer periods of time and at times, in increased doses. Such usage has not been as systematically studied as that suggested in the labeling and it is possible, as with many other medications, that there could be side effects (as noted in section 2.0 below)."

As a bariatric medical provider, I believe the probability of such side effects is less than the benefits to be realized by the appetite suppressant usage for longer periods of time, and when indicated, in larger doses. However, <u>you</u> must decide if you are willing to accept the risks of side effects, even if they might be serious, for the possible help the appetite suppressants used in this manner may give."

1.3 I understand it is my responsibility to follow the instructions carefully, and to report to the medical provider treating me for my weight, any significant medical problems that I think may be related to my weight control program, as soon as possible.

1.4 I understand the purpose of this treatment is to assist me in my desire to decrease my body weight and to maintain this weight loss. I understand my continuing to receive the appetite suppressant will be dependent on my progress in weight reduction and weight maintenance.

2.0 Risks of Proposed Treatment

2.1 I understand this authorization is given with the knowledge that the use of appetite suppressants for more than twelve weeks and in higher doses than the dose indicated in the labeling involves some kind of risks and hazards. The more common include: nervousness, sleeplessness, headaches, dry mouth, weakness, tiredness, psychological problems, medication allergies, high blood pressure, rapid heart beat and irregularities. These and other possible risks could, on rare occasion, be serious or fatal.

3.0 Risks Associated with being Overweight or Obese

3.1 I am aware that there are certain risks associated with remaining overweight or obese. Among them are:

- **High Blood Pressure**
- **Diabetes**
- **Heart Disease**
- **Arthritis of the joints, hips, knees and feet**

I understand these risks may be modest if I am modestly overweight, but that these risks can increase significantly the more overweight I am. I understand that thirty to forty percent of overweight or obese patients may have gallstones. A large percent of this group will develop symptomatic gallbladder disease during their lifetime. I understand that certain types of weight reduction programs may increase the chance of developing symptomatic gallbladder disease. The programs that are most likely to cause these symptoms are:

- **A very low caloric diet (VLCD) which is normally seen with total liquid protein diets.**
- **A program that has extremely rapid weight loss as one of its features.**

I understand that the ALASKA PREMIER HEALTH program utilizes meal replacement products as well as regular groceries and promotes a sensible steady weight loss in the range of four to eight pounds per month.

4.0 Guarantees

I understand that the success of the program will depend on my efforts, and that there are no guarantees or assurances that the program will be successful. I also understand that weight gain will re-occur unless I continue to practice sound dietary habits, and exercise routinely for the rest of my life.

5.0 Patient's Consent

5.1 I have read, and fully understand this consent form, and I realize I should not sign this form if all items have not been explained, or any questions I have concerning them, have not been answered to my complete satisfaction. I have been urged to take all the time I need in reading and understanding this form, and in talking with my medical provider regarding risks associated with the proposed treatment, and regarding other treatments not involving the appetite suppressants.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED TREATMENT, OR ANY QUESTIONS WHATSOEVER CONCERNING THE PROPOSED TREATMENT, OR OTHER POSSIBLE TREATMENTS, ASK YOUR MEDICAL PROVIDER NOW, BEFORE SIGNING THIS CONSENT FORM.

Patient:_____ **Date:**_____

Witness:_____

6.0 Medical Provider Declaration

6.1 I have explained the contents of this document to the patient, and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed concerning the benefits and risks associated with the use of the appetite suppressants, the benefits and risks associated with alternative therapies, and the risks of continuing in an overweight state. After being adequately informed, the patient has consented to therapy involving the appetite suppressants in the manner indicated above.

Medical Provider:_____ **Date:**_____