RULES FOR USE OF ANTI-OBESITY CONTROL MEDICATIONS

I, _____ authorize Middlesex Weight Management to assist me in my weight loss efforts. Obesity is as chronic disease with a complex etiology. Currently, Obesity is the first leading cause of preventable death in the US. Approximately 68% of our population is overweight or obese. Obesity is a serious disease with many consequences including but not limited to Diabetes Type 2, Blood Pressure, Heart Disease, certain types of Cancer, Arthritis, Sleep Apnea and High Cholesterol.

Research has shown that a weight loss of even five to ten percent of one's total body weight can significantly reduce health risks and lead to improvement in obesity related conditions. Anti-obesity medications offer an excellent tool to facilitate weight loss. However, the medications must be used in conjunction with attention to nutrition, lifestyle modification and increased physical activity.

Many anti-obesity medications are considered "controlled medications." By law, a controlled medication can only be prescribed from one facility at a time; therefore I agree that only Middlesex Weight Management will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician(s) at Middlesex Weight Management and any other providers from whom I receive treatment of all medications prescribed to me. I understand that the use of anti-obesity medications is contra-indicated with certain medical histories, allergies, or other medication use. I agree that I will be completely honest in disclosing this information and will notify my physician(s) at Middlesex Weight Management of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed by providers at Middlesex Weight Management. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous. I also understand that medications are typically considered after a trial of weight loss with nutritional/behavior modifications have been inadequate. If I am deemed a candidate for the medication program at Middlesex Weight Management, I am aware that the lowest effective dosage will be tried prior to increasing dosages.

I understand that medication prescriptions can be filled at a pharmacy of my choice. I agree to use only one pharmacy at a time to fill any scheduled anti-obesity prescriptions, and I give my permission for Middlesex Weight Management to notify area pharmacies of the terms of this agreement.

I will not share, sell, or trade my medication with anyone. I understand that doing so is illegal and will result in my discharge from the care of Middlesex Weight Management.

I understand that my treatment may involve, but is not limited to, the use of anti-obesity medications for an extended period of time. When appropriate, my physician may prescribe the medication or medications in an **"off label"** manner which may include prescribing the medication or medications in higher doses than that indicated by the Physician's Desk Reference or medications **used for reasons other than those approved by the FDA.** Treatment may also include the prescription of medication in various combinations when not labeled as such by the Food and Drug Administration (FDA).

Medications, including the anti-obesity medications, have labeling endorsed by both the makers of the medication and the FDA. I understand that research has found anorectic medications to be **helpful for periods far in excess of the proposed time, in larger doses than those suggested in the labeling, and in various combinations.** I understand that my physician is not required to use the medications as the labeling suggest, but he/she will use the labeling as a source of information with his/her own experience, the experience of colleagues, recent longer-term studies, and recommendations of university-based researchers.

I understand that my physician believes that the benefits of the medications exceed the probability of side effects from the medications. However, I understand that I must decide if I am willing to accept the risk of possibility serious side effects for the benefit that the anorectic medications may bring me.

Anorectic medications do impose risks including, but not limited to, restlessness, insomnia, headaches, dry mouth, fatigue, allergies, high blood pressure, rapid heartbeat, diarrhea, constipation, and dizziness. I understand that some may worsen depression and may pose a risk to an unborn fetus. If I begin a teratogenic medication (may pose a risk to a fetus) it is my responsibility to avoid pregnancy by using birth control and taking a monthly home pregnancy test. I understand that I must continue medications as prescribed by my provider, adhere to advised follow up protocols and obtain follow up laboratory tests a required. Medications may be discontinued by my provider if side effects occur or if I do not comply with prescribed follow up protocols.

I understand that I am to report any side effects or adverse reactions of my medications to the physician(s) at Middlesex Weight Management.

I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.

I agree that my physician(s) at Middlesex Weight Management may sometimes taper and/or stop my medication to evaluate its effect on my weight loss and/or hunger and health.

I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment in the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

PATIENT CONSENT
I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM. I UNDERSTAND THAT I SHOULD NOT SIGN THIS FORM IF ALL ITEMS HAVE NOT BEEN EXPLAINED TO ME OR IF ANY QUESTIONS CONCERNING THEM HAVE NOT BEEN ANSEWERED TO MY COMPELTE SATISFACTION. I HAVE DISCUSSED WITH MY PROVIDER THE RISKS ASSOCIATED WITH THE PROPOSED TREATMENT AND I UNDERSTAND OTHER TREATMENTS NOT INVOLING ANORECTIC MEDCATIONS ARE AVAILABLE TO ME.

Patient Signature: _____ Date: ____/____/_____

PHYSICIAN DELARATION

I have explained the contents of this document to the patient and have answered all of the patient's related questions. To the best of my knowledge, I feel that the patient has been adequately informed concerning the benefits and the risks associated with the use of anorectic medications and the risks of continuing in an overweight/obese state. After being adequately informed, the patient has consented to treatment involving the use of anti-obesity medications.

Physician Signature: _____ Date: ____/____/_____