MEDICAL WEIGHT MANAGEMENT PROGRAM

MyCatholicDoctor

Rules for use of anti-obesity medications

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT THE PHYSICIAN WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND YOUR EXPERIENCED SPECIALIST IN OBESITY MEDICINE DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

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 my physician will prescribe anti-obesity medications for me. I agree that it is my responsibility to inform my physician and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that he 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 of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I understand that for the best health care outcomes, my physician may need to,from time to time, consult with my primary care provider and/or specialists regarding my health and medications used.

I agree to take the medication as prescribed and directed by my physician. I understand that taking medications in any way other than as directed and prescribed could be dangerous to my health. I also understand that medications are typically considered after a trial of failed weight loss with nutritional/behavior modifications. If I am deemed a candidate for the medication program, 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 my physician to notify area pharmacies of the terms of this agreement.

I understand that prescriptions will not be re-written if lost, post-dated, or refilled before the appropriate time interval.

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 my physician.

I understand that the use of some of the anti-obesity medications beyond 12 weeks is considered “off label” or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my physician is an experienced specialist in obesity medicine who will, at times, elect/choose, when indicated, to use the anti-obesity medication(s) for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my physician as soon as possible.

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 understand that my physician 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 I achieve the desired weight loss to prevent weight re-gain.

Patient Name: _____

Patient Signature: _____ Date: _____