Weight's Over Health Care
Consent for Use of Phentermine or Phendimetrazine or "Off-Label"

OFF LABEL MEDICATION: When a drug is approved for medical use by the Food and Drug Administration ("FDA"), the manufacturer produces a "label" to explain its use. Once a medication is approved by the FDA, physicians may suggest use of the medication according to the recommendation on the label, or "Off-Label" for other purposes, if the Physician bases the medication's "off label" use on firm scientific method and/or experience, sound medical evidence and/or experience, and maintains records of the medication's use and any side effects.

Regarding Phentermine or Phendimetrazine, I understand the complications and side-effects to be uncommon but may include sleeplessness, dry mouth, difficulty urinating (in men), and/or increase in heart rate (I will purchase a pulse-ox). Very rarely, side effects may include palpitations or rapid heart rate, which if untreated can be serious and/or fatal. If I experience any side effects, I will stop taking the medication and seek immediate emergency medical assistance, and contact Dr. Colantonio immediately.

I understand the alternative to be the non-use of this medication, which would eliminate the potential side-effects noted above. My Private Medical Doctor ("PMD") is aware of my use of this medication and along with Dr. Colantonio, I will also follow-up with my PMD. And check my Oxygen-% and HR.

For patients whose BMI is less than 30, and/or patients taking prescribed appetite suppressants for more than three months: I understand that Phentermine or Phendimetrazine is approved and recommended by the FDA for weight loss assistance for a limited period of time (three months). Nevertheless, despite my BMI being less than the BMI recommended for the drug's usage, and/or I have used the medications for greater than three months, I have been fully informed of all relevant information and I wish to be prescribed Phentermine or Phendimetrazine for "Off Label" use.

I have provided and discussed all of my personal & medical information with Dr. Colantonio, the personal & medical information is accurate and complete, and I have not been prescribed any other similar or contraindicated medication within the last 14-21 days. I have read this Consent Form, and following a thorough physical examination, and after all of my questions and concerns have been answered & discussed, I understand that I am willing to accept the potential risks, and all risks, and that I have requested and have consented to the use of a Controlled Substance & Appetite Suppressant, to lose weight or maintain weight loss, decrease appetite, and/or control cravings. Along with Dr. Colantonio, my PMD will follow and monitor me as needed. My signature today applies to all follow-up visits in the future, after review of this consent at the follow-up visit.

Patient's Name Printed: _____

Patient's Signature: _____ **Date:** _____

I have explained the contents of this document to the patient and have answered all of the patient's questions. The patient has been adequately informed concerning the benefits and risks associated with the use of appetite suppressants, and the benefits and risks associated with alternative therapies. After being adequately informed, and weighing the risks and benefits, the patient has consented. After reviewing this consent in follow-up, the patient continues to consent.

Provider Signature: _____ **Date:** _____