Restore Mental Health
Informed Consent for Weight Loss
Medical Weight Management Program

Patient Name: _____ DOB: _____

Today's Date: _____ Provider: _____

Purpose of Treatment. I am voluntarily participating in a medically supervised weight-management program. I understand that treatment may include nutrition and activity counseling, behavior modification, laboratory testing, follow-up visits, and, when clinically appropriate, prescription medication.

I understand and acknowledge the following:

☐ Weight loss results vary. No specific amount or rate of weight loss has been promised or guaranteed.

☐ Successful treatment may require long-term changes in nutrition, physical activity, sleep, and other health behaviors. Weight regain can occur after treatment ends.

☐ My clinician will determine whether medication is appropriate based on my medical history, examination, medications, laboratory results, risks, and treatment goals.

☐ Possible side effects depend on the medication prescribed. Weight-loss medicines may cause gastrointestinal symptoms and may have uncommon but serious risks. I will review the medication-specific information supplied by my clinician/pharmacy and promptly report significant or persistent symptoms.

☐ I will tell the practice about all prescription medicines, over-the-counter medicines, supplements, allergies, medical conditions, prior bariatric procedures, and any history of pancreatitis, gallbladder disease, kidney disease, significant gastrointestinal disease, or endocrine/thyroid conditions.

☐ I will inform my clinician immediately if I am pregnant, planning pregnancy, breastfeeding, or believe I may be pregnant. Medication may need to be stopped or changed.

☐ I will seek urgent/emergency care for severe or persistent abdominal pain, repeated vomiting with inability to keep fluids down, symptoms of a serious allergic reaction, severe dehydration/fainting, or other symptoms that appear emergent.

☐ Alternatives include lifestyle treatment without medication, treatment with an FDA-approved medication when appropriate and available, referral to another specialist/program, bariatric surgery evaluation when appropriate, or choosing no treatment.

☐ I may ask questions at any time and may decline or discontinue treatment. Stopping a prescription medication should be discussed with the prescribing clinician when possible.

Patient Authorization

By signing below, I confirm that I have had the opportunity to ask questions, that the information I provided is accurate to the best of my knowledge, and that I consent to participate in the medical weight-management program and to the treatment plan ordered by my licensed clinician.

Printed Name: _____

Signature: _____