SUNDĀRI
FUNCTIONAL EATING

Hormone Consent

I, _____, authorize and give my Informed Consent to Bronwyn Mahtani, MD, for the administration of hormone replacement therapy.

Expected Benefits of Hormone Replacement Therapy:

_____ Expected benefits include control of symptoms associated with declining hormone levels. Possible benefits of this therapy may help prevent, reduce, or control physical diseases and dysfunction associated with declining hormone levels through hormonal replacement.

_____ I have been fully informed, and I am satisfied with my understanding that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration.

_____ I understand that my healthcare provider cannot guarantee any health benefits or that there will be no harm from the use of hormone replacement therapy.

Risks and Side Effects of Hormone Replacement Therapy:

_____ Some of the following risks/adverse reactions are derived from the official Food and Drug Administration "FDA" labeling requirements for these drugs for therapeutic drug levels in the bloodstream. My healthcare provider may prescribe these medications at dosages designed to achieve physiologic levels of hormones in my bloodstream or urine generally associated with those of a 20-25-year-old person and would be within the "normal" or "average" blood concentrations of that age group.

General:

_____ I understand that the general risks of this proposed therapy may include, but are not limited to, bruising, soreness or pain, and possible infection for hormones administered by injection or implantation.

_____ I understand that there are risks (both known and unknown) to any medical procedure, treatment, and therapy and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these known and unknown general risks.

_____ I understand that the conventional medical community and many Medical Doctors believe that Testosterone supplementation is contra-indicated in a patient with a history of prostate cancer and/or prostatic hypertrophy (BPH). I have been made fully informed by Bronwyn Mahtani, MD, of SUNDARI Functional Eating. I am completely satisfied with my understanding that the conventional medical community may view this proposed treatment as new, controversial, detrimental, and unnecessary to the Food and Drug Administration, given the present state of knowledge regarding the human aging process.

_____ While a study published in the New England Journal of Medicine in January 2004 reviewed 72 medical studies and found no evidence that testosterone therapy causes prostate cancer; however, I understand that questions have been raised about Testosterone as a cause of prostate cancer since it is an anabolic hormone and can increase the growth rate of cancer cells.

Testosterone is a prescription hormone; given by injection, pellet implantation, transdermal cream/gel, or patch.

_____ Risks of testosterone replacement include but are not limited to, stimulation of benign and malignant prostate tumors. Testosterone hormone replacement therapy is contraindicated in patients with known prostate cancer.

_____ Side effects of testosterone replacement may include but are not limited to, an increase in the red blood cells determined by periodic measuring of your red blood. It is not a common occurrence and generally poses no health risk; it can be corrected by donating blood or with therapeutic phlebotomy. Male pattern baldness, gynecomastia (breast enlargement), diminished sperm production, and a reduction in the size of the testicles may develop in men.

_____ Testosterone Replacement may reduce insulin requirements in insulin-dependent diabetics. Older male patients may be at a slightly increased risk for the development of prostate enlargement when replacing testosterone. The concurrent use of testosterone with corticosteroids may enhance edema (fluid retention) formation. Edema may be a complication with testosterone replacement in patients with pre-existing cardiac, renal, or hepatic disease. It is unknown whether testosterone replacement therapy will increase the risk of prostate cancer.

_____ The most common immediate side effects (occurring in approximately no more than 6% of users) include, but are not limited to, oily skin, acne, application site reaction, headache, hypertension (increased or high blood pressure), abnormal liver function tests, and non-cancerous prostate disorder. Other side effects may include moodiness, irritability, slight bruising at the injection site, greasy hair and skin, a strong body odor, increased hematocrit, exacerbation of sleep apnea, aggressiveness, alteration in insulin resistance, and alteration of lipid profile. Adjusting the dose can typically alter any side effect. I agree to cease using the testosterone, contact my provider, and, if necessary, seek immediate medical attention in the event I knowingly develop any adverse side effects.

_____ I understand that careful monitoring is crucial with Testosterone replacement therapy and agree to comply with monitoring recommendations while receiving Testosterone replacement therapy. Therapy monitoring to include but is not limited to blood tests every 3-6 months, annual physical examination, prostate exam (males) on the schedule that will be individually recommended, and mammogram and pap test (females) on the schedule that will be individually recommended.

Estrogen is a prescription hormone given by injection, orally, or by transdermal cream or patch.

_____ Risks associated with estrogen replacement include, but are not limited to, heart attacks, blood clot formation, gallstones, increased risk of uterine cancer (if progesterone is not administered concurrently), and fibroid tumors. The Women's Health Initiative study demonstrated increased risk when estrogen replacement is initiated 10 or more years after menopause.

_____ Estrogen is not a recommended course of therapy in women with a history of the following conditions: breast or uterine cancer, phlebitis and blood clots, gall bladder disease, uterine fibroma, and liver disease.

_____ Side effects may include, but are not limited to, increased body fat, fluid retention, uterine bleeding, depression, headaches, impaired glucose tolerance, and aggravation of migraines.

Progesterone is a prescription hormone given orally or by transdermal cream.

_____ Risks of progesterone replacement include but are not limited to: Progestins are not the same as natural progesterone. Progestins may cancel the protective effect of estradiol and promote constriction of the coronary arteries to a significant degree. Natural progesterone, on the other hand, may protect the endometrium, preserve the beneficial effects of estrogen on the cardiovascular system and exert no negative effects on the blood vessels that supply your heart. Progestins may cause birth defects, damage to nerve cells, blood clots, and breast cancer.

_____ Side effects of progesterone replacement may include but are not limited to nipple or breast tenderness, drowsiness, fluid retention, slight dizziness, anxiety, difficulty sleeping, depression, acne, rashes, hot flashes, appetite increases, and weight gain.

Thyroid Hormone is a prescription hormone taken by mouth.

_____ Risks/adverse reactions include but are not limited to palpitations and rapid heart rate, heart arrhythmias,

excitability, and increased metabolism. Cardiac sensitivity is a contraindication of thyroid replacement therapy. Excess amounts may increase the risk of osteoporosis in some people and suppress the body's own ability to manufacture its own thyroid hormone.

_____ Side effects may include, but are not limited to, sleep disturbances, fine trembling of fingers, excessive hunger and thirst, sweating, anxiety, and headaches.

DHEA is classified as a dietary supplement given by mouth or by transdermal cream.

_____ Risks of DHEA replacement include but are not limited to the worsening of certain cancers and should be avoided by men with existing prostate cancer and in women with breast cancer. DHEA replacement is not generally recommended in adults under age 35.

_____ Side effects of DHEA replacement are generally dose-related and may include but are not limited to acne or oily skin, hair growth on the face, arms, or legs, acne in women, prostate enlargement in men, male pattern baldness, decreased HDL cholesterol, fatigue, mood changes, weight gain, and insomnia.

Alternatives to Hormone Replacement Therapy:

_____ I understand the reasonable alternatives to hormone replacement therapy, which include leaving the hormone levels as they are and doing nothing. Risks may include but are not limited to experiencing symptoms of hormone deficiency and increased risk for aging-related diseases or dysfunction resulting from declining hormone levels. This alternative may result in the need to treat diseases or dysfunction associated with declining hormone levels as they appear clinically. Treating the symptoms of declining hormone levels as they develop with non-hormonal therapies

_____ Risks may include but are not limited to increased risk for aging-related diseases resulting from declining hormone levels.

My Compliance Obligation while Receiving Hormone Replacement Therapy:

_____ I agree to comply with the proposed treatment and therapy as prescribed, including the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or administrating the hormone(s) that may be prescribed to me, and consent to periodic monitoring when requested, which may include:

- Laboratory monitoring of blood or urine chemistries and hormone levels, physical examinations, and regular screening evaluations.

_____ I agree to notify you regarding all signs or symptoms of possible reactions to my therapy.

_____ I agree to comply with all other healthy lifestyle activities that have been individually recommended for me. I have completely disclosed my medical history, including prescription and non-prescription medications that I am currently taking or plan to take during my treatment, as well as any other over-the-counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements, to you. I agree to comply with the recommendations regarding the continuation or discontinuation of these preparations.

_____ In the future, I will receive recommendations in advance from you before stopping any prescribed therapeutic regimens or taking additional preparations that are not recommended by you. I certify that I am under the care of a physician(s) for all other medical conditions.

Research and Economic Interest:

_____ I understand that the prescribing practitioner is not engaged in any personal research and has no economic interests unrelated to my immediate care or treatment that may affect the physician's choice of treatment or medical judgment.

_____ I certify that I have been given the opportunity to ask any and all questions I have concerning the proposed treatment. I received all requested information, and all questions were answered. I fully understand that I have the right to not consent to hormone replacement therapy. I believe I have adequate knowledge upon which to base informed consent.

_____ I do now attest to reading and fully understanding this form and the contents and clinical meanings of such and discussing these procedures with my healthcare provider and consent to this treatment and hereby affix my signature to this authorization for this proposed long-term treatment. I have been given a copy of this consent form, and I understand fully any and all of the possibly represented implications and meanings of its writing and expectations.

_____ _____

Client's Printed Name Date

_____

Client's Signature