Memorial
WEIGHT LOSS & WELLNESS CENTER

Appetite Suppressant Informed Consent

Name:_____DOB:_____ Date of service:_____

Provider:_____MRN: _____

Memorial Weight Loss & Wellness Center recognizes that appetite suppressants can be helpful with weight loss. However, these medications alone will not sustain long-term weight loss. To ensure that you are a safe candidate for an appetite suppressant, the following criteria will be reviewed during your medical visit:

- ☐ BMI 27-29.9 with other comorbid conditions
- ☐ BMI ≥ 30
- ☐ Adequate calorie intake
- ☐ Making lifestyle changes
- ☐ Working with the multidisciplinary team
- ☐ Do not have any of the following health conditions:
  - Pregnancy
  - Arrhythmia (abnormal heart rhythm)
  - Cardiomyopathy (heart failure)

_____ (Initial) **Results:** I am aware that this medication is a tool to help with weight loss, and taking it without making lifestyle changes will not provide long-term, sustainable results.

_____ (Initial) **Multidisciplinary team:** I have been informed that weight-loss results are greater for individuals on an appetite suppressant when combined with a reduced-calorie diet and increased physical activity. I agree to work with the dietitian and physical therapist if my weight loss plateaus or as recommended by my medical provider.

_____ (Initial) **Caloric intake/energy expenditure:** I agree to track my caloric intake as well as my exercise frequency and duration while on this medication as this will ensure that I am consuming enough calories and weight loss is from fat and not muscle.

_____ (Initial) **Health conditions:** These medications are not recommended for certain health conditions. I will notify my prescribing medical provider if I develop one the of the following health conditions: pregnancy, arrhythmia (abnormal heart rhythm) or cardiomyopathy (heart failure).

_____ (Initial) **Refills:** I agree to provide my prescribing medical provider three (3) business days for any medication refill requests.

_____ (Initial) **Discontinuation:** I am aware that failing to follow these recommendations will result in discontinuation of this medication.

Patient signature: _____ Date: _____