Mason Park
Medical Clinic

MEDICAL WEIGHT MANAGEMENT CONSENT FORM

Our Medical Weight Management Program is a safe and effective approach for patients who've struggled with losing and/or maintaining a healthy weight and lifestyle on their own. In addition to our structured plans based on individual metabolic rates, we give our patients advantage in losing weight with an individual tailored treatment plan which can be a combination of following:

- Prescription Weight Loss Medication
- Proprietary Medical Grade Supplements
- Prescription Injectables
- Prescription Lipotropic Creams
- Nutrition Counseling
- Healthy Diet and Exercise

Initial Visit

- One-on-one consultation with a provider
- Body composition analysis
- May include weight loss focused bloodwork

Continuity of care

- Monthly follow up care with our licensed healthcare provider to review progress
- May include a monthly consultation with our licensed nutritionist
- Healthy diet and lifestyle changes

You'll return for monthly follow-up visits with the provider and nutritionist (as needed) to review your progress and receive your next 30 day prescriptions of supplements, injections and/or creams.

To continue with the program, you MUST be seen by a provider monthly until you reach your desired weight loss goal.

I, _____, authorize Dr. Trinh and associated health care providers, to help me in my weight-reduction efforts. I fully understand that this program shall consist of a reduction in caloric intake, regular exercise and behavioral lifestyle changes and my treatment may include the use of a combination of appetite suppressants and and/or injections. I further understand that in order to continue on the program, I must have regular follow up appointments and show continued weight loss.

Regarding the use of any prescription medication, I understand that there are potential risks involved. Side effects may include nervousness, constipation, insomnia, headaches, dry mouth, weakness, fatigue, medication allergy, increased blood pressure and increased or irregular heart

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rate. I understand that these and other risks could be serious or in rare cases life threatening.

Initials _____

I agree not to take any other weight loss medications, injectables or any other supplements other than those prescribed by Dr. Trinh and further agree to inform the staff of ANY changes in my medication or medical history.

Initials _____

I understand that I can be successful without the use of appetite suppressants or injections as long as I am following a reduced calorie nutrition plan and increasing my activity level, however the use of such medications and injections may significantly help with my weight loss progress. I understand the risks associated with being overweight or obese include the possibility of high blood pressure, diabetes, heart disease, stroke, cancer, arthritis and pain in the joints, gallbladder disease and even sudden death.

Initials _____

I understand that much of the success of the program will depend on my efforts and that there are no guarantees that the program will be successful. I also understand that obesity is a chronic, lifelong condition that may require changes in eating habits and permanent changes in behavior to be treated successfully. I have read and fully understand this consent form and it has been fully explained to me. My questions have been answered to my complete satisfaction.

Initials _____

Patient Name _____ DOB:_____

Date _____

Patient Signature _____

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Weight Loss Program Questionnaire

DATE:_____

1. I decided to come to Mason Park Medical Clinic to help with my weight because:

   _____

2. My weight one year ago _____lb.
3. The most I ever weighed (non-pregnant) was _____lb.
4. I began to gain weight because

   _____

5. My worst food habit is

   _____

6. I am a stress eater Yes / No
7. I eat in the middle of the night Yes / No
8. My significant other has a weight issue Yes / No

During the past 3 months, I have had episodes of excessive overeating where I ate more than what most people would eat in a similar period of time:

- If *"NO"* go to **Beverage** box below
- If *"YES"* complete the following:

Please ***circle*** Yes or No for each following questions:

1. During these episodes I feel I have NO CONTROL over my eating Yes / No
2. I eat during these episodes even when I am not hungry Yes / No
3. During these episode I feel embarrassed by how much I ate Yes / No
4. During these episode I feel disgusted with myself, or guilty afterward Yes / No
5. In the past 3 months, I have sometimes made myself vomit to try to control my weight Yes / No

Beverages: I drink the following routinely (circle all that apply):

Beverages	**# per week**
Fruit Juice	
Sweetened Tea	
Sports Drinks	
Energy Drinks	
Regular Sodas	
Diet Sodas	

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Typical Meals for me include: (if “none”, please not that)

Breakfast	**Lunch**	**Supper**	**Snacks**

I have done the following **weight loss program** before:

Program	**Year**	**Result**

1. I have used weight loss medication before: No Yes If yes, which?

   _____

2. I am currently using weight loss products: No Yes If yes, which?

   _____

3. The person(s) closest to me support my intentions to do this program:

   No Yes Unsure

4. Long term, I would like to maintain my weight at _____lbs.

Patient Name _____ DOB:_____

Patient Signature _____