Michele Delzer, CNP

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Informed Consent for Male Hormone Therapy

Patient Name: _____
Date of Birth: _____
Date: _____

Consent to Treat

I consent to evaluation and treatment by RCHP, Michele Delzer CNP, and staff for:

- **Testosterone replacement therapy (TRT)**
- **Hormone optimization including DHEA and estradiol**
- **Any medically necessary supportive therapy**

I understand that hormone therapy may involve off-label use and is not FDA approved for wellness, weight loss, or anti-aging purposes unless medically indicated.

Signature: _____

Date: _____

Alternative Treatments

I have been informed of alternative options:

1. **No hormone therapy**
2. **Natural approaches (weight loss, nutrition)**

3. **Alternative medications to increase testosterone**

I choose to proceed with the treatment plan recommended by RCHP.

Signature: _____

Date: _____

Risks and Side Effects

I acknowledge that testosterone therapy may cause:

- **Acne, hair loss, breast enlargement, testicular atrophy**
- **Fluid retention, high blood pressure, high libido, infertility**
- **Increased hematocrit (risk of blood clots)**

Rare serious risks include: prostate cancer progression, cardiovascular events (heart attack, stroke, clot).

I understand topical testosterone must be used with care to avoid accidental exposure to others.

Signature: _____

Date: _____

Safety and Monitoring

- **I will have lab monitoring of hormone levels and hematocrit.**

- **I will stay current with age-appropriate screenings (prostate, colon, cardiac, etc.) through my primary care provider.**
- **I release RCHP and staff from liability for unrelated screenings or conditions.**
- **I will promptly inform RCHP of any abnormal findings from other providers.**

Signature: _____

Date: _____

Patient Responsibilities

- **I will follow all medication instructions.**
- **I will maintain care with a primary care provider.**
- **I understand therapy may be experimental or off-label.**

Signature: _____

Date: _____

Consent & Indemnification

I authorize RCHP and Michele Delzer CNP to evaluate, treat, and obtain necessary labs. I release and indemnify RCHP and staff from liability related to treatment, medications, or undisclosed health information.

Printed Name: _____
Signature: _____

Date: _____