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RCHP Informed Consent for Female Hormone Therapy

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

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1. Consent to Treat

I hereby give my consent to evaluation and treatment by RCHP, Michele Delzer, CNP, and other healthcare practitioners associated with RCHP for the following:

- **Menopause or menopausal symptoms: including potential repletion of estrogen/estradiol, progesterone, DHEA, testosterone.**
- **Other hormone imbalances: Thyroid and adrenal abnormalities.**
- **Other treatments as deemed necessary: Nutritional deficiencies, IV infusion therapy, weight management, and any additional therapies recommended by my provider.**

I understand that hormone therapy, B12 injections, and thyroid optimization may involve off-label use and are not FDA-approved for purposes such as health optimization, anti-aging, weight loss, or wellness, except when medically necessary.

I consent to the administration of hormone therapy and other medications as appropriate to my diagnosis, condition, and treatment goals.

Signature: _____

Date: _____

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2. Alternative Treatments

I have been informed of alternative treatment options, including:

1. **Leaving hormone levels untreated.**
2. **Addressing age-related diseases as they appear.**
3. **Using synthetic, non-bioidentical pharmaceutical hormones instead of bioidentical therapy.**

I understand these alternatives and choose to proceed with the treatment plan prepared by RCHP.

Signature: _____

Date: _____

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3. Side Effects and Potential Risks

I understand that common side effects of hormone therapy in women may include:

- **Breast swelling or discomfort**
- **Fluid retention and dizziness**

- **Break-through bleeding and irregular menstrual cycles**
- **Acne, unwanted hair growth, headaches**
- **Slight deepening of the voice, slight enlargement of the clitoris**

Serious potential risks include:

- **Blood clots**
- **Cardiovascular disease (heart attack, stroke)**
- **Acceleration of gynecological cancers**
- **Worsening of ovarian cysts, uterine fibroids, endometriosis, and fibrocystic breast disease**

I acknowledge that most common side effects resolve with time and may be managed by adjusting doses or adding medications.

I understand the need for extreme caution with topical testosterone to prevent accidental exposure to children or women, which may cause hormone-related side effects.

Signature: _____

Date: _____

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4. Safety and Monitoring

Although studies suggest bioidentical hormone therapy is generally safe, there is ongoing debate about risks related to cardiovascular disease and cancer.

I understand that:

- **RCHP will monitor my hormone levels and relevant lab values.**
- **Maintaining up-to-date screenings (DEXA, mammograms, PAP smears, pelvic exams, colonoscopies, cardiac screenings) is my responsibility.**
- **I will notify RCHP immediately of any abnormal findings or pregnancy while on therapy.**

By signing, I release RCHP, Michele Delzer CNP, and staff from liability for events related to cardiovascular disease, breast, ovarian, uterine, cervical, or colon cancer during treatment.

Signature: _____

Date: _____

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5. Hormone Therapy Acknowledgment

- **Menopause hormone therapy (MHT) may be bioidentical or synthetic, FDA-approved or compounded.**
- **Compounded hormones are not FDA-approved, and safety is not guaranteed.**
- **All forms carry risks of blood clots, stroke, cardiovascular disease, and breast cancer.**

- **Therapy should be used at the lowest effective dose for symptom relief, but patients may choose longer-term use with full understanding of risks.**

I have received educational materials including the FDA publication "Bio-identicals: Sorting myths from facts" and had all my questions answered.

Signature: _____

Date: _____

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6. Off-Label Medication Consent

I understand that some prescribed medications may be off-label (approved for a different condition, dose, or population). I accept potential risks, including unknown long-term effects.

Signature: _____

Date: _____

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7. Obligations and Representations

- **I will follow prescribed dosing and administration instructions.**
- **I am under the care of a primary care provider or specialist for other conditions.**
- **I understand that RCHP is providing specialized care, not primary care.**

- **I acknowledge that some treatments may be experimental or not widely recognized as medically necessary.**

Signature: _____

Date: _____

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8. Consent and Indemnification

I authorize RCHP, Michele Delzer CNP, and staff to evaluate and treat me, including obtaining blood work prior to therapy. I release RCHP and staff from liability related to treatment outcomes or failure to disclose medical information.

I agree to indemnify, defend, and hold harmless RCHP, Michele Delzer CNP, and staff from any claims, damages, or losses related to my care.

Printed Name: _____
Signature: _____

Date: _____