Copper Valley Medical
Caring, Compassionate Healing

Patient Name: _____ **Age/DOB:** ____ ___________

Consent for Treatment with Phentermine

I understand and acknowledge:

- Phentermine is a U.S. DEA Controlled Substance, and will be prescribed carefully, including a review of my profile on the Arizona Prescription Management Program. A copy of my report will be collected at 3-month intervals, or more frequently.
- This medication should not be taken by anyone under the following circumstances:
  - Any of the following heart conditions:
    - Coronary Artery Disease
    - Stroke
    - Arrhythmias
    - Congestive Heart Failure
    - Uncontrolled Hypertension
  - Within 2 weeks of taking a drug in the class known as Monoamine Oxidase Inhibitors
  - Hyperthyroidism
  - Glaucoma
  - A past or current history of drug abuse
    - This drug is chemically and pharmacologically related to amphetamines.
  - A woman who is or is planning pregnancy or breast feeding a newborn.
- Phentermine may impair your ability to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby release the doctor and the facility from liability associated with this treatment.

Consent: I have read and understand this acknowledgement and desire to receive the injections described. This consent may be revoked at any time.

_____

Signature of Patient Date