SUNSET CLINIC
FAMILY MEDICINE • URGENT CARE

# SUNSET CLINIC'S WEIGHT LOSS PROGRAM

Dear _____, DOB _____/_____/_____,

It is our pleasure to introduce our innovative Medically Supervised Weight Loss Program. Every patient is unique and will lose weight differently. Sunset Clinic and staff will work with each patient individually to achieve weight loss goals in order to adopt a healthier lifestyle and reduce risks associated with being overweight or obese. Being in a healthy weight range will reduce co-morbidities, along with enhancing ones quality of life. The following is an informed consent indicating the use, requirements, risks, and side effects of using the medication(s) associated with our weight loss program.

**Procedure and alternatives**: I request the use of Phentermine to assist with my weight loss regimen. I understand it is a short-term adjunctive use as part of weight-reduction regimen along with exercise, behavioral modification, and caloric restriction in the management of obesity or being overweight with medical risk factors. I understand there is no guarantee for the effectiveness of Phentermine. Much of the success of the program will depend on efforts of the patient in combination with committing to long-term lifestyle modifications. I authorize providers of Sunset Clinic to assist me in my weight-reduction efforts. I understand my treatment may involve appetite suppressants and may be prescribed with "off-label use". Furthermore, I understand that although the usual duration is short-term (~12 weeks), Sunset Clinic may need to extend the duration of treatment based on how much weight an individual may need to lose in order to achieve a healthy weight range.
Initials: _____

**Requirements**: I understand that an EKG and basic blood work may be necessary to rule out any conditions that would disqualify me from the program and as initial work up to assure there is no underlying medical conditions. An EKG and blood work is required every 12 months. Prior to starting the weight loss program, I will fully disclose all medical condition(s) and medication(s) to Sunset Clinic staff/providers; as some medical and/or cardiac conditions and medications may be contraindicated with medications used in Sunset Clinic's weight loss program.
I agree that I am, and will be under the care of another medical provider for all other medical conditions. Sunset Clinic can work in conjunction with, but will not replace my regular primary care physician. I

understand that the diet program is designed to only address weight loss, and all other health matters should be through a standard medical evaluation.
Initials: _____

**Risks and side effects**: I am aware that Phentermine has associated risks, which include, but are not limited to:

- Development of primary pulmonary hypertension
- Development of serious valvular heart disease
- Effects on the ability to engage in potentially hazardous tasks
- The risk of an increase in blood pressure

Initial: _____

Adverse reactions may include potential for developing tolerance and risk of dependence. I will keep my diet medications in a safe place to prevent theft, accidental overdose, misuse or abuse. I understand selling or giving away Phentermine may harm others and is against the law.
Initial: _____

Furthermore, I have read fully read the attached ***Phentermine Patient Information*** that was provided for me and understand the risks associated with taking Phentermine.
Initial: _____

Thank you for taking part in our medically supervised weight loss program. We hope to incorporate cutting-edge medications to help you reach your goals quickly and safely. Sunset clinic is committed to providing our patients with the most safe and effective means for weight loss. With weight loss and long-term changes, we will embark on a new lifestyle to a healthier you!