**Patient Consent Form**

**BPC-157 Treatment**

**Patient Information**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction**

You are being asked to participate in a treatment involving the use of BPC-157, a peptide currently under investigation for its potential healing and regenerative properties. This form provides information about the treatment, potential risks and benefits, and your rights as a participant.

**Purpose of the Treatment**

BPC-157 is a synthetic peptide derived from a protein found in the stomach. It has shown promise in preclinical studies for its ability to promote healing of various tissues, including muscles, tendons, and the gastrointestinal tract. However, it is important to note that BPC-157 is not approved by the FDA for human use and is considered experimental.

**Description of the Treatment**

If you agree to participate, you will receive BPC-157 according to the following protocol:

* **Dosage**: [Specify dosage]
* **Administration Method**: [Specify method, e.g., subcutaneous injection]
* **Duration of Treatment**: [Specify duration]

**Potential Benefits**

The potential benefits of BPC-157 treatment may include:

* Enhanced healing of injured tissues
* Reduction in inflammation
* Improved recovery time from injuries

However, as an experimental treatment, these benefits are not guaranteed, and the long-term effects are unknown.

**Potential Risks and Side Effects**

Possible risks and side effects of BPC-157 may include, but are not limited to:

* Pain or discomfort at the injection site
* Allergic reactions
* Unknown long-term health effects

Because BPC-157 is still under investigation, there may be risks that are not yet known.

**Voluntary Participation and Withdrawal**

Your participation in this treatment is voluntary. You have the right to refuse or discontinue the treatment at any time without penalty or loss of benefits to which you are otherwise entitled. If you decide to withdraw, you should inform your healthcare provider immediately.

**Confidentiality**

All information collected about you during this treatment will be kept confidential. Your identity will not be disclosed in any reports or publications resulting from this treatment.

**Alternatives**

If you choose not to participate in this experimental treatment, your healthcare provider will discuss alternative treatment options with you.

**Consent**

By signing this form, you acknowledge that you have read and understood the information provided, have had the opportunity to ask questions, and agree to participate in the treatment with BPC-157.

**Patient’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Provider’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**

If you have any questions or concerns about the treatment, please contact:

* **Healthcare Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_