**Patient Consent Form**

**Sermorelin Treatment**



**Patient Information**

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

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

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

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

**Introduction**

You are being asked to participate in a treatment involving Sermorelin, a synthetic peptide analog of growth hormone-releasing hormone (GHRH). This form provides information about the treatment, potential benefits, risks, and your rights as a participant.

**Purpose of the Treatment**

Sermorelin is being used to stimulate the production and release of growth hormone from the pituitary gland. This treatment aims to increase growth hormone levels in individuals with growth hormone deficiency or those seeking to enhance their overall well-being and vitality.

**Description of the Treatment**

If you agree to participate, you will receive Sermorelin according to the following protocol:

* **Dosage**: [Specify dosage, frequency, and route of administration]
* **Duration of Treatment**: [Specify duration]

**Potential Benefits**

The potential benefits of Sermorelin treatment may include:

* Increased energy and vitality
* Improved muscle tone and strength
* Enhanced mood and cognitive function
* Reduction in signs of aging

**Potential Risks and Side Effects**

Possible risks and side effects of Sermorelin may include, but are not limited to:

* Injection site reactions (pain, redness, swelling)
* Headache
* Nausea or stomach upset
* Allergic reactions (rash, itching, difficulty breathing)
* Changes in blood sugar levels
* Changes in heart rate or blood pressure

**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 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 Sermorelin.

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