**Patient Consent Form**

**Tesamorelin Treatment**

**Patient Information**

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

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

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

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

**Introduction**

You are being asked to participate in a treatment involving Tesamorelin, a medication used to reduce excess abdominal fat in HIV-infected patients with lipodystrophy. This form provides information about the treatment, potential benefits, risks, and your rights as a participant.

**Purpose of the Treatment**

Tesamorelin is a synthetic peptide that stimulates the release of growth hormone (GH). It is specifically approved for reducing visceral adipose tissue (VAT) in HIV-infected patients experiencing lipodystrophy due to antiretroviral therapy.

**Description of the Treatment**

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

* **Dosage**: [Specify dosage, typically 2 mg]
* **Administration Method**: Subcutaneous injection
* **Frequency**: Once daily
* **Duration of Treatment**: [Specify duration]

**Potential Benefits**

The potential benefits of Tesamorelin treatment may include:

* Reduction in abdominal fat
* Improved body composition
* Potential improvements in metabolic health

**Potential Risks and Side Effects**

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

* Injection site reactions (pain, redness, swelling)
* Muscle pain
* Joint pain
* Swelling in hands or feet
* Increased blood sugar levels
* Carpal tunnel syndrome symptoms (numbness, tingling in the hands)
* Hypersensitivity reactions (rash, itching)

**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 Tesamorelin.

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