**Patient Consent Form**

**Thymosin Beta 4 Treatment**

**Patient Information**

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

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

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

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

**Introduction**

You are being asked to participate in a treatment involving Thymosin Beta 4, a peptide with potential therapeutic applications in tissue repair and regeneration. This form provides information about the treatment, potential benefits, risks, and your rights as a participant.

**Purpose of the Treatment**

Thymosin Beta 4 is being used for its potential to promote tissue repair and regeneration in various conditions, including injuries, wounds, and inflammatory disorders. This treatment aims to harness the peptide's natural properties to support the body's healing processes.

**Description of the Treatment**

If you agree to participate, you will receive Thymosin Beta 4 according to the following protocol:

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

**Potential Benefits**

The potential benefits of Thymosin Beta 4 treatment may include:

* Enhanced tissue repair and regeneration
* Accelerated wound healing
* Reduction in inflammation and associated symptoms

**Potential Risks and Side Effects**

Possible risks and side effects of Thymosin Beta 4 may include, but are not limited to:

* Injection site reactions (pain, redness, swelling)
* Allergic reactions (rash, itching, difficulty breathing)
* Changes in blood pressure or heart rate
* Flu-like symptoms

**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 Thymosin Beta 4.

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

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

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

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

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

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

Shape

**Additional Information**

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

**Healthcare Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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