GLOBAL MEDICAL CENTER
REGENERATIVE MEDICINE OF LOUISIANA

NEW MALE PATIENT PACKAGE

In order to determine if you are a candidate for bio-identical testosterone, we need lab work and your health history forms. We will evaluate your information to determine if Hormone Replacement Therapy can help you live a healthier life. If possible please complete the following task before your appointment.

AT LEAST 1 WEEK BEFORE YOUR

☐Complete medical history form ☐Complete lab work

It is your responsibility to find out if your insurance company will cover the cost of labs, and which lab to go to. Please note that it can take up to a week for your lab results to be received by our office. If you are not insured or have a high deductible, call our office for self-pay lab work. Our preferred lab is CPL (Clinical Pathology Laboratories); they are located at Southern Surgical Hospital, 1700 Lindberg Drive Slidell, LA 70458 and are open Monday-Friday 8AM – 4PM (closed 12PM-1PM).

Your blood work panel MUST include the following test:

☐CBC
☐Complete Metabolic Panel
☐Lipid Panel (must be fasting)
☐Vitamin D, 25-Hydroxy
☐PSA Total
☐Testosterone Free & Total
☐SHBG
☐LH
☐TSH
☐T3, Free
☐T4, Free
☐T.P.O. Thyroid Peroxidase
☐Estradiol

Post Hormone Replacement Therapy labs needed 4-6 weeks from start date:

☐CBC
☐Complete Metabolic Panel
☐Lipid Panel (must be fasting)
☐Testosterone Free & Total
☐FSH
☐SHBG
☐LH

PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____
(LAST) (FIRST) (MIDDLE)

Date of Birth: _____ Age: _____ Weight: _____ Occupation:_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? ☐ YES ☐ NO

In Case of Emergency Contact:_____ Relationship: _____

Home Phone:_____ Cell Phone:_____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
ADDRESS CITY STATE ZIP

Marital Status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with Partner ☐ Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Any known drug allergies: _____

Have you ever had any issues with anesthesia?

□No □Yes, please explain_____

Current Medications: _____

_____

_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

_____

Surgeries, list all and when: _____

_____

_____

MEDICAL HISTORY

Medical Illnesses:

□ Anxiety
□ Arrhythmia
□ Arthritis
□ Blood clot/pulmonary emboli
□ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
□ Diabetes
□ Depression
□ Elevated PSA
□ Fibromyalgia
□ Heart attack
□ Heart bypass
□ Heart disease
□ Hemochromatosis
□ Hepatitis or HIV (any form)
□ High blood pressure
□ High cholesterol
□ Hypertension
□ Lupus or other auto immune disease
□ Prostate enlargement
□ Prostate exam in the last 12 months
□ Psychiatric disorder
□ Stroke
□ Testicular or prostate cancer
□ Thyroid disease
□ Trouble passing urine or take Flomax or Avodart
□ Cancer (type): _____ Year: _____

Social:

□ I am sexually active
□ I want to be sexually active
□ I have completed my family
□ I have had a vasectomy
□ My sex has suffered
□ I haven't been able to have an orgasm
□ I have used steroids for athletic purposes

Habits:

□ I Smoke cigarettes or cigars _____ a day.
□ I drink alcoholic beverages _____ a week.
□ I drink 10+ alcoholic beverages/ week.
□ I use caffeine _____ a day.

Family History:

□ Alzheimer's Disease
□ Breast Cancer
□ Diabetes
□ Heart Disease
□ Osteoporosis

SYMPTOM CHECKLIST

	NEVER	MILD	MODERATE	SEVERE
Acne				
Decline in general well being				
Fatigue				
Joint pain/muscle ache				
Excessive sweating				
Sleep problems				
Increased need for sleep				
Irritability				
Nervousness				
Anxiety				
Depressed mood				
Exhaustion/ lacking vitality				
Declining mental ability/ focus/concentration				
Feeling you have passed your peak				
Feeling burned out/ hit rock bottom				
Decreased muscle strength				
Weight gain/ belly fat/ inability to lose weight				
Rapid hair loss				
Migraines/ headaches				
FEMALES				
Facial Hair				
Breast tenderness				
Vaginal dryness				
Hot flashes				
MALES				
Breast development				
Shrinking testicles				
Decreased beard growth				
Decreased morning erections				
Decreased desire/ libido				
Decreased ability to perform sexually				
Infrequent or absent ejaculations				
No results from E.D. medications				

HORMONE REPLACEMENT FEE

Although more insurance companies are reimbursing patients for the Hormone Replacement Therapy, there is no guarantee. You will be responsible for payment in full at the time of your procedure. Upon request, we will give you the necessary paperwork for you to send and file with your insurance company for reimbursement.

New Patient Consult Fee $125
Female Hormone Pellet Insertion Fee $350
Male Hormone Pellet Insertion Fee $650
Initial Injectable Testosterone RX $ 300
Additional Injectable Testosterone RX $ 200
Initial Labs $250
Follow Up Labs $150

We accept the following forms of payment:

Master Card, Visa, American Express, Personal Check, Discover, and Cash.

PRINT NAME: _____
SIGNATURE: _____ DATE: _____
OFFICE STAFF: _____ DATE: _____

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INFORMED CONSENT FOR BIO-IDENTICAL HORMONE REPLACEMENT THERAPY

Please read and review this consent form and ask questions for clarification if needed. Then, initial each statement indicating understanding and agreement, and sign at the bottom of the form.

STATEMENT OF PATIENT:

____ I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment. I agree to proceed with treatment and to comply with recommended dosages.

____ I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a physician, my primary care physician, or other specialist. I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc.

____ I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of bio-identical and other hormone treatments and have had all my questions answered. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of bio-identical hormone therapy.

____ I have been informed that insurance companies may not pay for physician evaluation, laboratory testing, and medications. I therefore agree to pay for all services including physician evaluation, laboratory tests and pharmacy charges, with the understanding that I may not be reimbursed by my insurance company.

____ I certify this form has been fully explained to me, that I have read it or have had it read to me. I have been educated on the benefits, risks, and possible adverse reactions associated with bio-identical hormone replacement therapy. I have been given the opportunity to ask any questions about hormone replacement therapy, potential complications, required testing, and costs and have had them answered to my satisfaction. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits. I fully understand what I am signing and hereby request and consent to treatment using bioidentical hormone replacement therapy.

SIGNATURE OF PATIENT: _____ DATE: _____

NAME (PRINT): _____

STATEMENT OF PRESCRIBER: I have explained the therapy, its intended benefits and risks, and possible reactions to the patient. I have confirmed that the patient understands the risks and benefits, has no further questions and gives consent to initiate bio-identical hormone replacement therapy.

SIGNATURE OF PRESCRIBER: _____ DATE: _____

WHAT MIGHT OCCUR AFTER A PELLET INSERTION

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

□ **Hormonal:** Most people experience significant improvement in general well-being with HRT. Especially in younger men, there is a risk that testosterone HRT can suppress the development of sperm and reduce the sperm count during therapy. However, to date, this appears to be a reversible process and once testosterone is discontinued, the sperm count is restored.

□ **Fluid Retention:** Testosterone stimulates the muscle to grow and retain water, which may result in a weight change of two to five pounds. This is only temporary. This happens frequently with the first insertion, and especially during hot, humid weather conditions.

□ **Overproduction of Red Blood Cells:** This is known as erthrocytosis. Testosterone can sometimes stimulate the bone marrow to produce more red blood cells causing the blood to become too viscous (thick). Close monitoring of your blood count will allow early detection. This condition can simply be reversed by donating blood if ordered by your provider.

□ **Swelling of The Hands & Feet:** This is common in hot and humid weather. It may be treated by drinking lots of water, reducing your salt intake, taking cider vinegar capsules daily, (found at most health and food stores) or by taking a mild diuretic, which the office can prescribe.

□ **Mood Swings/Irritability:** These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5-HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

□ **Facial Breakout:** Some pimples may arise if the body is very deficient in testosterone. This lasts a short period of time and can be handled with a good face cleansing routine, astringents and toner. If these solutions do not help, please call the office for suggestions and possibly prescriptions.

□ **Hair Loss:** This is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. Prescription medications may be necessary in rare cases.

□ **Hair Growth:** Testosterone may stimulate some growth of hair on your chin, chest, nipples and/or lower abdomen. This tends to be hereditary. You may also have to shave your legs and arms more often. Dosage adjustment generally reduces or eliminates the problem.

□ **Breast:** Breast or nipple sensitivity may occur. This is due to testosterone being converted to an excess of estrogen in the body and an increase in blood supply to the breast tissue. An estrogen-blocking medication can be prescribed if symptoms develop. To date, there has been no evidence connecting testosterone HRT to breast cancer.

I acknowledge that I have received a copy and understand the instructions on this form.

_____
Patient Initials

_____
Melissa Brown, ANP-BC

POST-INSERTION INSTRUCTIONS

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. Therefore, certain changes might develop that can be bothersome.

- ☐ Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after **3 days**. It must be removed as soon as it gets wet. The inner layer is either waterproof foam tape or steri-strips. They should be removed in **7 days**.
- ☐ We recommend putting an ice pack on the insertion area a couple of times for about 20 minutes each time over the next 4 to 5 hours. *Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.*
- ☐ Do not take tub baths or get into a hot tub or swimming pool for **7 days**. You may shower but do not scrub the site until the incision is well healed (about 7 days).
- ☐ **No major exercises for the incision area for the next 7 days, this includes running, elliptical, squats, lunges, etc.**
- ☐ The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- ☐ The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take 50 mg Benadryl for relief orally every 6 hours. Caution this can cause drowsiness!
- ☐ You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- ☐ You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- ☐ If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- ☐ Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- ☐ Please call if you have any pus coming out of the insertion site, as this is NOT normal.

Reminders:

Remember to go for your post-insertion blood work 4-6 weeks after the insertion. Most men will need reinsertions of their pellets 5-6 months after their initial insertion. Most women will need re-insertions of their pellets 3-4 months after their initial insertion.

Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for a re-insertion. The charge for the second visit will only be for the insertion and not a consultation.

Additional Instructions: _____

_____

I acknowledge that I have received a copy and understand the instructions on this form.

_____
Patient Initials

_____
Melissa Brown, ANP-BC