OPTIMAL
SLEEP & WEIGHT LOSS CLINIC

13000 Harbor Center Drive, #202, Woodbridge, VA, 22192
Tel: 703-955-5355 Fax: 703-955-5348

CONSENT FOR USE OF ANTI-OBESITY/SLEEP MEDICINE CONTROLLED MEDICATIONS

Check all that apply: SLEEP MEDICINE [ ] WEIGHT LOSS MEDICINE [ ]

NOTE: SIGNING THIS FORM DOES NOT GUARANTEE THAT YOUR PROVIDER(S) AT OPTIMAL SLEEP AND WEIGHT LOSS CLINIC WILL FIND YOU TO BE AN APPROPRIATE CANDIDATE FOR ANTI-OBESITY/SLEEP/WAKE/STIMULANT MEDICATIONS, BUT ONLY THAT YOU HAVE READ, UNDERSTOOD, AND AGREE TO THE TERMS OF MEDICATION USAGE SHOULD YOU AND OPTIMAL SLEEP AND WEIGHT LOSS CLINIC PROVIDERS DECIDE UPON THEIR USAGE NOW OR IN THE FUTURE.

Some anti-obesity and sleep/wake medications are considered “controlled medications.” By law, a controlled medication can only be prescribed from one facility at a time; therefore, I agree that only OPTIMAL SLEEP AND WEIGHT LOSS CLINIC provider will prescribe anti-obesity/sleep/wake/stimulant medications for me. I agree that it is my responsibility to inform my provider(s) at OPTIMAL SLEEP AND WEIGHT LOSS CLINIC and any other providers from whom I receive treatment of all medications prescribed to me. **I understand that the use of anti-obesity/sleep/wake/stimulant medications is contraindicated with certain medical histories, allergies, or other medication use**. I agree that I will be honest in disclosing this information and will notify my provider(s) at OPTIMAL SLEEP AND WEIGHT LOSS CLINIC of any changes to my medical history or medication usage. I understand that failure to do so can be dangerous to my health.

I agree to take the medication only as prescribed and directed. I understand that taking medications in any way other than as directed and prescribed could affect my health and be dangerous. I further agree to random urine drug screening if necessary.

I understand that the use of some medications considered controlled substances beyond 12 weeks is considered “off label” or not initially approved by the U.S. Food and Drug Administration (FDA). I understand that my provider(s) will work with me and, at times, elect or choose, when indicated, to use a controlled substance for longer periods of time as deemed appropriate for my individual treatment.

I understand that I am to report any side effects or adverse reactions of my medications to my provider(s) at OPTIMAL SLEEP AND WEIGHT LOSS CLINIC.

For Obesity Medicine: I understand that it is my responsibility to follow the instructions carefully and that the purpose of this treatment is to assist me in my desire to decrease my body weight for improvement of health and to maintain weight loss. I understand that the purpose of medications for weight loss is to be used as an adjunct to a program that includes nutrition and/or physical activity and/or behavior modification.
I understand that much of the success of the program will depend on my efforts and that there are **NO GUARANTEES** in medical treatment of the disease of obesity. I also understand that I will have to continue monitoring my weight after active weight loss.

Patient Signature: _____ Date: _____

Patient Name (printed): _____