

# OptiPepRx

## Testosterone Therapy Disclosure & Informed Consent

I acknowledge that I have voluntarily requested testosterone optimization services through OptiPepRx. If a licensed provider determines therapy is appropriate, treatment may include testosterone replacement or related therapies based on clinical assessment and laboratory evaluation.

### Important Information

- 1. Individualized Medical Decision** Therapy, dose, and route of administration are determined by a licensed provider and may require ongoing monitoring and adjustments.
- 2. No Guarantee of Results** Symptom improvement varies and no specific outcomes are guaranteed.
- 3. Potential Side Effects and Risks** Risks may include acne/oily skin, hair changes, mood changes, swelling/fluid retention, increased red blood cell count (high hematocrit), elevated blood pressure, changes in cholesterol, breast tenderness, and worsening sleep apnea.
- 4. Fertility Considerations** Testosterone therapy may reduce fertility and sperm production. I agree to inform my provider if I am trying to conceive now or within the next 6-12 months.
- 5. Prostate and Cancer Considerations** Therapy may not be appropriate for individuals with certain prostate or breast cancer histories. Monitoring may be recommended based on clinical factors.
- 6. Blood Clot and Cardiovascular Considerations** Certain individuals may have increased cardiovascular or clotting risks. My provider will evaluate risk factors and determine appropriate monitoring.
- 7. Patient Responsibilities** I agree to provide accurate medical history, follow dosing instructions, complete recommended labs, and report urgent symptoms (e.g., chest pain, shortness of breath, severe headache, or leg swelling).
- 8. Monitoring and Follow-Up** Ongoing labs may include testosterone levels, CBC/hematocrit, CMP, lipids, and PSA when clinically indicated. Therapy may be paused or adjusted based on results.

### Patient Attestation

By signing below, I confirm that I have read and understood this disclosure, had the opportunity to ask questions, and consent to medical evaluation and, if deemed appropriate by a licensed provider, treatment under the provider's clinical judgment.

This disclosure is informational and does not replace individualized medical advice. Final determination of appropriateness is made by the reviewing provider.

Patient Name (print): \_\_\_\_\_

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

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

DOB: \_\_\_\_\_

If you experience severe symptoms (e.g., chest pain, shortness of breath, fainting, severe abdominal pain, or signs of allergic reaction), seek urgent or emergency medical care.