Harmony Community Clinic
1103 W Hibiscus Blvd, Suite 302A, Melbourne, FL 32901 · harmonycommunityclinic@gmail.com

Informed Consent: Testosterone Replacement Therapy (Men)

Includes Controlled Substance Agreement

Patient name (print) _____ Date of birth _____ Date _____

1. Treatment description

Testosterone replacement therapy is used to treat low testosterone (hypogonadism) confirmed by symptoms and blood tests. It may be given as an injection, cream, or gel. Blood tests are required before starting and regularly during treatment.

- Form: ☐ Injection ☐ Cream / gel ☐ Other: _____ Product: ☐ FDA-approved ☐ Compounded (see form HCC-10)

2. Possible benefits and alternatives

Possible benefits include improved energy, mood, sex drive, muscle mass, and bone strength. Alternatives include lifestyle changes (weight loss, sleep, exercise), medications that stimulate natural testosterone production, treating underlying causes, or no treatment.

3. Risks

- **Increased red blood cells (high hematocrit),** which thickens the blood and raises the risk of clots. This may require a dose change, a break from treatment, or blood donation.
- **Infertility:** testosterone lowers sperm production and may shrink the testicles. Fertility may not fully return after stopping. If I want children now or in the future, I will tell my provider.
- Blood clots in the legs or lungs (DVT / PE).
- Heart and blood vessels: studies have shown mixed results. A large 2023 study did not find a higher risk of heart attack or stroke in men with low testosterone, but did find more cases of irregular heartbeat (atrial fibrillation), blood clots in the lungs, and kidney injury.
- Increase in PSA, enlargement of the prostate, and worsening urinary symptoms. Testosterone may stimulate the growth of existing prostate or breast cancer.
- Acne, oily skin, hair loss on the scalp, breast tenderness or enlargement.
- Fluid retention, swelling, increased blood pressure, worsening sleep apnea.
- Mood changes, irritability, or aggression.
- Changes in cholesterol and liver tests.
- My own testosterone production decreases during treatment. After stopping, it may take months to recover and symptoms may return.
- **Gels and creams** can transfer to women and children through skin contact and cause unwanted effects. I will wash my hands, cover the area, and avoid skin-to-skin contact until it dries.

I have read and understand the risks listed above. _____ Initials

4. Screening questions

	Yes	No
Do you have or have you had prostate or breast cancer?	☐	☐
Do you have a history of blood clots, heart attack, or stroke?	☐	☐
Do you have untreated sleep apnea or uncontrolled heart failure?	☐	☐
Are you trying to have children now or in the future?	☐	☐
Do you have trouble urinating?	☐	☐

5. Controlled Substance Agreement

Testosterone is a Schedule III controlled substance under federal law. I agree that:

- I will receive testosterone prescriptions only from Harmony Community Clinic and will tell my provider about any other controlled substances I am prescribed.
- I will use one pharmacy for this medication: _____.
- I will take the medication only as prescribed and will never share, sell, or give it to anyone. Doing so is illegal.
- I will keep my medication in a safe, secure place. Lost or stolen medication may not be replaced, and early refills will not be given.
- I will complete laboratory monitoring as ordered (including testosterone, blood count, PSA, and others). Prescriptions may be paused until labs are done.
- The clinic may check the Florida prescription monitoring database (E-FORCSE) and may stop prescribing if this agreement is not followed.

I understand and agree to the Controlled Substance Agreement. _____ Initials

No guarantee: I understand that medicine is not an exact science. Results vary from person to person, and no promise or guarantee has been made to me about the results of this treatment.

Right to refuse or stop: I may refuse this treatment or stop it at any time. Stopping will not affect my right to receive other care at Harmony Community Clinic. Charges for services already provided or medications already dispensed still apply.

If I have a severe reaction, such as trouble breathing, swelling of the face or throat, chest pain, fainting, sudden vision changes, or severe pain, I will call 911 or go to the nearest emergency room right away, and then notify the clinic.

I consent to testosterone replacement therapy. _____ Initials

Signatures

By signing below, I confirm that I have read this form (or had it read to me) in a language I understand, that I had the opportunity to ask questions and all of my questions were answered, and that I agree to its terms voluntarily.

Patient name (print)	Patient signature	Date

Parent / guardian / legal representative (print, if applicable)	Relationship to patient	Representative signature	Date

Provider name and credentials	Provider signature	Date

Tell us about your visit

Your opinion helps other families find quality care. After your visit, scan this code with your phone camera to leave Harmony Community Clinic a review on Google.

Thank you for trusting us with your health.