OFFICE USE ONLY – INITIAL PELLET INSERTION FORM FEMALE

NAME: _____ **DATE**: _____

Height: _____ **Weight:** _____**Blood Pressure:** _____**Temperature:** _____

CURRENT MEDICATIONS: _____

SURGERY/ HISTORY: **Hysterectomy**: ( ) **YES** ( ) **NO** **Ovaries**: ( ) **YES** ( ) **NO**

Last Pap: _____ **Last Mammogram**: _____ **Normal**: ( ) **YES** ( ) **NO**

_____

SYMPTOMS:_____

_____

LABS:

Estradiol: _____ Testosterone: _____ FSH: _____ Vitamin D: _____ Vitamin B12: _____

TSH: _____ Free T3: _____ TPO: _____ CBC: _____ Chem Panel: _____

LDL: _____ HDL: _____ Triglycerides: _____ Insertion site: Left Hip ( ) Right Hip ( )

PLAN:
This patient presents today for hormone pellets. The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of Testosterone and/or Estradiol pellet implants was signed. An area in the hip was prepped with Chloraprep swabs. A sterile drape was applied. 1% Lidocaine with epinephrine and sodium bicarbonate was injected to anesthetize the area. A small transverse incision was made using a number 11 blade. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone and or Estradiol pellet(s) were inserted through the cannula into the subcutaneous tissue. Bleeding was minimal. Steri-strips were applied. A sterile dressing was applied. The patient tolerated the procedure well. Postoperative instructions were reviewed and a copy given to the patient. Pellets used are as follows:

TREAT WITH:

1. **Testosterone**: _____ MG's **Testosterone Lot Numbers**: _____
2. **Estradiol**: _____ MG's **Estradiol Lot Numbers**: _____
3. **Progesterone**: _____ **CYCLE** or **CONTINUOUS** (circle one)
4. **Femara**: _____ **Arimidex**: _____ **DIM**: _____
5. **Vitamin ADK**: _____ **Thyroid:**_____ **Iodine:**_____
6. **Probiotic:** _____ **Omega 3:** _____
7. **Other**: _____

Female Testosterone and/or Estradiol Pellet Insertion Consent Form

Name:_____ Today's Date:_____

(Last) (First) (Middle)

Bio-identical hormone pellets are hormones, biologically identical to the hormones you make in your own body prior to menopause. Estrogen and testosterone were made in your ovaries and adrenal gland prior to menopause. Bio-identical hormones have the same effects on your body as your own estrogen and testosterone did when you were younger, without the monthly fluctuations (ups and downs) of menstrual cycles.

Bio-identical hormone pellets are plant derived and are FDA monitored, but not approved for female hormonal replacement. The pellet method of hormone replacement has been used in Europe and Canada for many years and by select OB/GYNs in the United States. You will have similar risks as you had prior to menopause, from the effects of estrogen and androgens, given as pellets.

Patients who are pre-menopausal are advised to continue reliable birth control while participating in pellet hormone replacement therapy. Testosterone is category X (will cause birth defects) and cannot be given to pregnant women.

My birth control method is: (please circle)

Abstinence Birth control pill Hysterectomy IUD Menopause Tubal ligation Vasectomy Other

CONSENT FOR TREATMENT: I consent to the insertion of testosterone and/or estradiol pellets in my hip. I have been informed that I may experience any of the complications to this procedure as described below. These side effects are similar to those related to traditional testosterone and/or estrogen replacement. **Surgical risks are the same as for any minor medical procedure and are included in the list of overall risks below:**

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives; extrusion of pellets; hyper sexuality (overactive Libido); lack of effect (from lack of absorption); breast tenderness and swelling especially in the first three weeks (estrogen pellets only); increase in hair growth on the face, similar to pre-menopausal patterns; water retention (estrogen only); increased growth of estrogen dependent tumors (endometrial cancer, breast cancer); birth defects in babies exposed to testosterone during their gestation; growth of liver tumors, if already present; change in voice (which is reversible); clitoral enlargement (which is reversible). The estradiol dosage that I may receive can aggravate fibroids or polyps, if they exist, and can cause bleeding. Testosterone therapy may increase one's hemoglobin and hematocrit, or thicken one's blood. This problem can be diagnosed with a blood test. Thus, a complete blood count (Hemoglobin & Hematocrit) should be done at least annually. This condition can be reversed simply by donating blood periodically.

BENEFITS OF TESTOSTERONE PELLETS INCLUDE: Increased libido, energy, and sense of well-being; increased muscle mass and strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.

I have read and understand the above. I have been encouraged and have had the opportunity to ask any questions regarding pellet therapy. All of my questions have been answered to my satisfaction. I further acknowledge that there may be risks of testosterone and or estrogen therapy that we do not yet know, at this time, and that the risks and benefits of this treatment have been explained to me and I have been informed that I may experience complications, including one or more of those listed above. I accept these risks and benefits, and I consent to the insertion of hormone pellets under my skin. This consent is ongoing for this and all future pellet insertions.

I understand that payment is due in full at the time of service. I also understand that it is my responsibility to submit a claim to my insurance company for possible reimbursement. I have been advised that most insurance companies do not consider pellet therapy to be a covered benefit and my insurance company may not reimburse me, depending on my coverage. I acknowledge that my provider has no contracts with any insurance company and is not contractually obligated to pre-certify treatment with my insurance company or answer letters of appeal.

_____ _____

Print Name **Signature** **Today's 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.

- **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.

- **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.

- **UTERINE SPOTTING/BLEEDING**: This may occur in the first few months after an insertion, especially if you have been prescribed progesterone and are not taking properly: i.e. missing doses, or not taking a high enough dose. Please notify the office if this occurs. Bleeding is not necessarily an indication of a significant uterine problem. More than likely, the uterus may be releasing tissue that needs to be eliminated. This tissue may have already been present in your uterus prior to getting pellets and is being released in response to the increase in hormones.

- **MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. They will disappear when enough hormones are in your system. 5HTP 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**: 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.

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

_____	_____	_____
Print Name	**Signature**	**Today's Date**

Future Hope
TOTAL HEALTH

Post-Insertion Instructions for Women

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. 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 **3 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.
- Do not take tub baths or get into a hot tub or swimming pool for **3 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 **3 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 Benadryl for relief, 50 mg. 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 **6 weeks** after the 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.

_____ _____ _____

Print Name **Signature** **Today's Date**

Female Treatment Plan

° The following medications or supplements are recommended in addition to your pellet therapy.

° Please refer to the supplement brochure to help you understand why these are beneficial.

° Unless specified, these can be taken any time of day without regards to meals.

Supplements: These may be purchased in our office. When you run out they can be mailed to you for your convenience.

_____ **ADK 5,000 (vitamins A, D3 and K2)**

_____ 1 a day_____ 2 a day for _____ weeks, then one a day

_____ **ADK 10,000 (vitamins A, D3 and K2)**

_____ 1 a day_____ 2 a day for _____ weeks, then one a day

_____**Probiotic** Take 1 a day for one week, then take 2 a day starting week 2

_____**Omega 3** Take 1 -4 softgels a daily with meal

_____**BioTE Iodine Plus** 12.5 mg daily with food or as directed by physician

_____**DIM** Take 1 a day

Prescriptions: **These have been called into your preferred pharmacy**

_____ **Progesterone/Prometrium** nightly

____100 mg ____ 200 mg

Please do not skip doses of this medication as it can result in vaginal bleeding or an increased risk for endometrial cancer.

_____ **Nature-throid** _____ mg every morning. This should be taken on an empty stomach. Please wait 30 minutes before putting anything else on your stomach. This includes coffee, food, medications, vitamins or supplements. _____ Sample given

_____Wean off Synthroid/levothyroxine: alternate your desiccated thyroid (Nature-throid) every other day with Synthroid/levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

_____ **Spironolactone** 100 mg daily ____ (other) _____

_____ Wean off your antidepressant (see wean protocol) ____ (other) _____

Please call or email for any questions about these recommendations.

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

_____ _____ _____

Print Name **Signature** **Today's Date**