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**You & I Primary Care, Aesthetics and Wellness**

**Leonard Einstein, APRN, NP-C**

1380 NE Miami Garden Drive, Suite 274, Miami, Fl 33179 │ Tel: 954-655-6559 │ Email: [youandimedspa@gmail.com](mailto:youandimedspa@gmail.com)

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MALE NEW PATIENT PACKAGE**

The contents of this package are your first step to restore your vitality. Please take the time to read this carefully and answer all the questions as completely as possible.

Thank you for your interest in hormone optimization. In order to determine if you are a candidate for bioidentical hormone replacement, we need laboratory information and your medical history forms. We will evaluate your information prior to your consultation to determine if the Biote Method® of hormone replacement therapy can help you live a healthier life.

Please complete the following tasks before your appointment: **2 weeks or more before your scheduled consultation** get your blood lab drawn at the lab of your choice. If you have had labs drawn at another office in the last year, please get a copy of those results to us BEFORE your labs are drawn as insurance may not cover duplicate lab tests. We request the tests listed below. **It is your responsibility to find out if your insurance company will cover the cost and which lab to use.**

Your blood work panel MUST include the following tests

**Estradiol \_\_\_\_\_\_\_\_ Testosterone Free \_\_\_\_\_\_\_\_ Testosterone Total \_\_\_\_\_\_**

**PSA,** total (ages 55-69 or high-risk) **\_\_\_\_\_\_\_ T3 Free \_\_\_\_\_\_\_\_ T4 Free \_\_\_\_\_\_\_\_**

**TPO (thyroid peroxidase) \_\_\_\_\_\_ TSH \_\_\_\_\_\_ CBC \_\_\_\_\_\_\_\_**

**Complete Metabolic Panel \_\_\_\_\_\_ Vitamin D, 25-hydroxy \_\_\_\_\_\_\_ Vitamin B12 \_\_\_\_\_\_\_**

**Lipid panel (optional) \_\_\_\_\_\_\_ Homocysteine (optional) \_\_\_\_\_\_\_ A1C (optional) \_\_\_\_\_\_\_\_**

**Reverse T3 (optional) \_\_\_\_\_\_\_ Anti-thyroglobulin antibody (optional) \_\_\_\_\_\_\_**

**Male post-insertion labs needed at 4 weeks**:

**Estradiol \_\_\_\_\_\_\_\_\_\_\_**

**Testosterone Free \_\_\_\_\_\_\_\_\_\_\_**

**Testosterone total \_\_\_\_\_\_\_\_\_\_\_\_**

**PSA, total \_\_\_\_\_\_\_\_\_\_\_\_**

(If PSA was borderline

on first insertion)

**CBC** \_\_\_\_\_\_\_\_\_\_\_

**Free T3 \_\_\_\_\_\_\_\_\_\_**

**Free T4 \_\_\_\_\_\_\_\_\_\_**

(only if you’ve been prescribed thyroid medication)

**Other \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Miscellaneous** other labs (possibly needed)

**Prolactin** (age < 40 OR T < 300) **\_\_\_\_\_\_\_**

**Sleep study** (snoring or T < 300) \_\_\_\_\_\_\_

**Semen analysis** \_\_\_\_\_\_\_

**Other** \_\_\_\_\_\_\_

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**MALE HEALTH ASSESSMENT**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark “none”

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptoms** | **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** | **Very Severe (4)** |
| **Sweating (**night sweats or excessive sweating) |  |  |  |  |  |
| **Sleep problems** (difficulty falling asleep, sleeping through the night or waking up too early) |  |  |  |  |  |
| Increased need for sleep or falls asleep easily after a meal |  |  |  |  |  |
| **Depressive mood** (feeling down, sad, lack of drive) |  |  |  |  |  |
| **Irritability (**mood swings, feeling aggressive, angers easily) |  |  |  |  |  |
| **Anxiety (**inner restlessness, feeling panicked, feeling nervous, inner tension) |  |  |  |  |  |
| **Physical exhaustion** (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation) |  |  |  |  |  |
| **Sexual problems** (change in sexual desire or in sexual performance) |  |  |  |  |  |
| **Bladder problems** (difficulty in urinating, increased need to urinate) |  |  |  |  |  |
| **Erectile changes** (weaker erections, loss of morning erections) |  |  |  |  |  |

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**MALE HEALTH ASSESSMENT (Continued)**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark “none”

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptoms** | **None (0)** | **Mild (1)** | **Moderate (2)** | **Severe (3)** | **Very Severe (4)** |
| **Joint and muscular symptoms** (joint pain or swelling, muscle weakness, poor recovery after exercise) |  |  |  |  |  |
| Difficulties with memory |  |  |  |  |  |
| Problems with thinking, concentrating or reasoning |  |  |  |  |  |
| Difficulty learning new things |  |  |  |  |  |
| Trouble thinking of the right word to describe persons, places or things when speaking |  |  |  |  |  |
| Increase in frequency or intensity of headaches/migraines |  |  |  |  |  |
| Rapid hair loss or thinning |  |  |  |  |  |
| Feel cold all the time or have cold hands or feet |  |  |  |  |  |
| **Weight gain**, increased belly fat, or difficulty losing weight despite diet and exercise |  |  |  |  |  |
| Infrequent or absent ejaculations |  |  |  |  |  |
| **Total score** |  |  |  |  |  |

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

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**HORMONE REPLACEMENT FEE ACKNOWLEDGMEN & INSURANCE DISCLAIMER**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preventative medicine and bioidentical hormone replacement is a unique practice and is considered a form of alternative medicine. Even though the physicians and nurses are board certified as medical doctors, nurses, nurse practitioners and/or physician assistants, insurance does not recognize bioidentical hormone replacement as necessary medicine BUT rather more like plastic surgery (aesthetic medicine). Therefore, bioidentical hormone replacement is not covered by health insurance in most cases. Insurance companies are not obligated to pay for our services (consultations, insertions or pellets, or blood work done through our facility). We require payment at time of service and, if you choose, we will provide a form to send to your insurance company with a receipt showing that you paid out of pocket. WE WILL NOT, however, communicate in any way with insurance companies. This form and your receipt are your responsibility and serve as evidence of your treatment. We will not call, write, pre-certify, appeal nor make any contact with your insurance company. If we receive a check from your insurance company, we will not cash it but will return it to the sender. Likewise, we will not mail it to you. We will not respond to any letters or calls from your insurance company. For patients who have access to Health Savings Account, you may pay for your treatment with that credit or debit card. Some of these accounts require that you pay in full ahead of time, however, and request reimbursement later with a receipt and letter. This is the best idea for those patients who have an HSA as an option in their medical coverage. It is your responsibility to request the receipt and paperwork to submit for reimbursement.

**New patient office visit fee 125 $**

**Female hormone pellet insertion fee $ 700**

**Initial Labs and Follow up laps $ \_\_\_\_**

**We accept the following forms of payment: Visa , Master Card, Discover, Care Credit , Cherry**

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_**

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**HIPAA INFORMATION AND CONSENT FORM**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, [www.hhs.gov](http://www.hhs.gov).

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other health-care providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient

9. You have the right to request restrictions in the use of your protected health information and to request

change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

**Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_**

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**MALE PATIENT QUESTIONNAIRE & HISTORY**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we send messages via text regarding appointments to your personal cellphone \_\_\_\_ Yes \_\_\_\_ No

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact you by email \_\_\_ Yes \_\_\_ No

In case of Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status** ( *check one*) \_\_\_ Married \_\_\_ Divorced \_\_ Widow \_\_ Living with Partner \_\_\_ Single

In the event we cannot contact you by the means you have 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:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MALE PATIENT QUESTIONNAIRE & HISTORY (continuation)**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social**:

\_\_\_\_ I am Sexually Active OR \_\_\_\_\_\_ I want to be sexually active \_\_\_\_ I do not want to be sexually active

\_\_\_\_ I have complete my family OR \_\_\_\_\_\_ I have not completed my family

\_\_\_\_ My sex life has suffered OR \_\_\_\_\_\_ I have not been able to have an orgasm or it is very difficult.

**Habits**:

\_\_\_\_ I **smoke** cigarettes or cigars \_\_\_\_\_\_ per day \_\_\_I use **e-cigarretes** \_\_\_\_\_ a day

\_\_\_\_ I use **caffeine** \_\_\_\_\_ a day

\_\_\_\_ I drink **alcoholic** beverages \_\_\_\_ per week \_\_\_ I drink more than 10 alcoholic beverages a week

**Drug Allergies:**

**Drug Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any issues with **local anesthesia**? \_\_\_ Yes \_\_\_ No Do you have a **latex** **allergy**? \_\_ Yes \_\_ No

**Medications** currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current hormone replacement ? \_\_\_\_ Yes \_\_\_No if yes, what ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Hormone Replacement Therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

\_\_\_\_\_ Heart Disease \_\_\_\_\_ Diabetes \_\_\_ Osteoporosis \_\_\_\_ Alzheimer’s/Dementia

\_\_\_\_ Breast Cancer \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MALE PATIENT QUESTIONNAIRE & HISTORY (continuation)**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pertinent medical/surgical history**

Cancer (type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_

Elevated PSA: \_\_\_\_\_\_\_\_ Trouble passing urine \_\_\_\_\_\_\_\_\_

Taking medicine for prostate or male-pattern balding: \_\_\_\_\_\_\_\_\_\_\_\_

History of anemia \_\_\_\_\_\_\_\_ Vasectomy: \_\_\_\_\_\_ Erectile dysfunction: \_\_\_\_\_\_\_\_\_

Testicular or prostate cancer \_\_\_\_\_\_\_\_\_ Prostate enlargement or BPH \_\_\_\_\_\_\_\_\_\_

Kidney disease or decreased kidney function \_\_\_\_\_\_\_\_\_\_ Frequent blood donations \_\_\_\_\_\_\_\_\_

Non-cancerous testicular or prostate surgery \_\_\_\_\_\_\_\_\_\_ Severe snoring \_\_\_\_\_\_\_\_\_

Taking medicine for high cholesterol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth Control Method:**

Not applicable \_\_\_\_\_ None - planning pregnancy in the next year \_\_\_\_\_\_\_\_\_

Depend on partner’s contraception \_\_\_\_\_\_\_ Vasectomy \_\_\_\_\_\_\_ Condoms \_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MALE PATIENT QUESTIONNAIRE & HISTORY (continuation)**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activity Level:**

\_\_\_\_ Low – Sedentary \_\_\_\_\_ Moderate – Walk/jog/workout infrequently

\_\_\_\_ Average – Walk/Jog/Workout 1 to 3 times per week

\_\_\_\_ High – Walk/Jog/Workout regularly 4+ times per week

**Medical history:**

\_\_\_\_\_ High blood pressure or hypertension \_\_\_\_\_ Heart disease

\_\_\_\_\_ Atrial fibrillation or other arrhythmia \_\_\_\_\_ Blood clot and/or a pulmonary embolism

\_\_\_\_\_ Depression/anxiety \_\_\_\_Chronic liver disease (hepatitis, fatty liver, cirrhosis) \_\_\_\_\_ Arthritis \_\_\_\_ Hair thinning \_\_\_\_ Sleep apnea

\_\_\_\_\_ High cholesterol \_\_\_\_ Stroke and/or heart attack

\_\_\_\_\_HIV or any type of hepatitis \_\_\_\_\_ Hemochromatosis \_\_\_\_\_\_Psychiatric disorder

\_\_\_\_\_ Thyroid disease \_\_\_\_\_ Diabetes \_\_\_\_\_\_Thyroid disease

\_\_\_\_\_\_ Lupus or other autoimmune disease \_\_\_\_\_ Other

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**MALE FLOW CHART FOR LAB RESULTS & BIOTE DOSAGES**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical history** (check all that apply): \_\_\_\_\_\_\_ BPH \_\_\_\_ Elevated PSA \_\_\_\_Prostate cancer

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Total Testosterone**  **(ng/dl)** | **Free Testosterone**  **(ng/dl)** | **E2 Level**  **(pg.ml)** | **PSA** | **Testosterone mg used** | **Comments** |
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**PELLET INSERTION CONSENT FOR MALES**

My nurse practitioner (N.P) has recommended testosterone therapy delivered by a pellet inserted under my skin for treatment of symptoms I am experiencing related to low testosterone levels. The following information has been explained to me prior to receiving the recommended testosterone therapy.

OVERVIEW Bioidentical testosterone is a form of testosterone that is biologically identical to that made in my own body. The levels of active testosterone made by my body have decreased, and therapy using these hormones may have the same or similar effect(s) on my body as my own naturally produced testosterone. The pellets are a delivery mechanism for testosterone, and bioidentical hormone replacement therapy using pellets has been used since the 1930’s. There are other formulations of testosterone replacement available, and different methods can be used to deliver the therapy. The risks associated with pellet therapy are generally similar to other forms of replacement therapy using bioidentical hormones

RISKS/COMPLICATIONS Risks associated with pellet insertion may include : bleeding from incision site, bruising, fever, infection, pain, swelling, pellet extrusion which may occur several weeks or months after insertion, reaction to local anesthetic and/or preservatives, allergy to adhesives from bandage(s), steri strips or other adhesive agents. Some individuals may experience one or more of the following complications:  acne, anxiety, breast or nipple tenderness or swelling, insomnia, depression, mood swings, fluid and electrolyte disturbances, headaches, increase in body hair, fluid retention or swelling, mood swings or irritability, rash, redness, itching, lack of effect (typically from lack of absorption), transient increase in cholesterol, nausea, retention of sodium, chloride and/or potassium, weight gain or weight loss, thinning hair or male pattern baldness, increased growth of prostate and prostate tumors which may or may not lead to worsening of urinary symptoms, hypersexuality (overactive libido) or decreased libido, erectile dysfunction, painful ejaculation, ten to fifteen percent shrinkage in testicular size, and/or significant reduction in sperm production, increase in neck circumference, overproduction of estrogen (called aromatization) or an increase in red blood cell formation or blood count (erythrocytosis). The latter can be diagnosed with a blood test called a complete blood count (CBC). This test should be done at least annually.  Erythrocytosis can be reversed simply by donating blood periodically, but further workup or referral may be required if a more worrisome condition is suspected.

I have read or have had this form read to me.

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

Witness name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

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**You & I Primary Care, Aesthetics and Wellness**

**Leonard Einstein, APRN, NP-C**

1380 NE Miami Garden Drive, Suite 274, Miami, Fl 33179 │ Tel: 954-655-6559 │ Email: [youandimedspa@gmail.com](mailto:youandimedspa@gmail.com)

**PELLET INSERTION CONSENT FOR MALES (Continued)**

All types of testosterone replacement can cause a significant decrease in sperm count during use. Pellet therapy may affect sperm count for up to one year. If you are planning to start or expand your family, please talk to your provider about other options. Additionally, there is some risk, even when using bioidentical hormones, that testosterone therapy may cause existing cases of prostate cancer to grow more rapidly. For this reason, a prostate specific antigen blood test (PSA) is recommended for men ages 55-69 before starting hormone therapy, even if asymptomatic. Testing is also recommended for younger individuals considered high risk for prostate cancer. The test should be repeated each year thereafter.  If there is any question about possible prostate cancer, a follow-up referral to a qualified specialist for further evaluation may be required.

CONSENT FOR TREATMENT: I agree to immediately report any adverse reactions or problems that may be related to my therapy to my physician/ Nurse practitioner or health care provider’s office, so that it may be reported to the manufacturer. Potential complications have been explained to me, and I acknowledge that I have received and understand this information, including the possible risks and potential complications and the potential benefits. I also acknowledge that the nature of bioidentical therapy and other treatments have been explained to me, and I have had all my questions answered. I understand that follow-up blood testing will be necessary **four (4) weeks after my initial pellet insertion** and then at least **one time annually** thereafter. I also understand that although most patients will receive the correct dosage with the first insertion, some may require dose changes. I understand that my blood tests may reveal that my levels are not optimal which would mean I may need a higher or lower dose in the future. Furthermore, I have not been promised or guaranteed any specific benefits from the insertion of testosterone pellets. I have read or have had this form read to me. I accept these risks and benefits, and I consent to the insertion of testosterone pellets under my skin performed by my provider (Nurse Practitioner). This consent is ongoing for this and all future insertions in this facility until I am no longer a patient here, but I do understand that I can revoke my consent at any time. I have been informed that I may experience any of the complications to this procedure as described above.

I have read or have had this form read to me.

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

Witness name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

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**-OFFICE USE ONLY –**

**INITIAL PELLET INSERTION FORM MALE**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_ Blood pressure: \_\_\_\_\_\_\_\_\_\_\_\_ Temperature: \_\_\_\_\_\_\_\_\_\_

**Current medications**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery/past medical history**: \_\_\_\_\_ None

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lab results:**

**Estradiol**: \_\_\_\_\_\_\_\_\_\_ **Total testosterone**: \_\_\_\_\_\_\_\_\_\_ **Free Testosterone: \_\_\_\_\_\_\_\_\_ PSA \_\_\_\_\_\_\_\_\_\_**

**Vit D**: \_\_\_\_\_\_\_ **Vit B12**: \_\_\_\_\_\_\_\_\_\_ **TSH**: \_\_\_\_\_\_\_\_ **Free T3:** \_\_\_\_\_\_\_**Free T4:** \_\_\_\_\_\_ **TPO**: \_\_\_\_\_\_

**CBC**: \_\_\_\_\_\_ **Chem panel** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Total cholesterol**: \_\_\_\_\_\_\_\_\_\_ **LDL**: \_\_\_\_\_\_\_\_\_\_ **HDL**: \_\_\_\_\_\_\_\_

**Triglycerides**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Prolactin ( <40 y/o): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**OFFICE USE ONLY**

**– INITIAL PELLET INSERTION FORM MALE-**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure note:**

The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of testosterone pellet implants was signed. An area was prepped. The area was then infiltrated with local anesthesia. A small incision was made using a #11 blade scalpel. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone 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. Post-insertion instructions were reviewed, and a copy was given to the patient.

**Prep solution:**  \_\_\_\_\_ Alcohol \_\_\_\_\_\_ Chloraprep \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Local anesthetic**: \_\_\_\_\_ **1% lido w/ep** \_\_\_\_ cc (ml) \_\_\_\_\_\_ **1% lido** \_\_\_\_ cc (ml) other \_\_\_\_\_\_\_\_\_\_\_\_

**Sodium bicarbonate cc: \_\_\_\_\_\_\_\_\_\_**

**Insertion site: \_\_\_\_\_\_\_\_\_ Left hip \_\_\_\_\_\_ Right hip Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treat with:**

**Testosterone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mg Testosterone lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thyroid Rx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mg daily Probiotic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADK 5 or ADK10: \_\_\_\_\_\_\_\_\_\_\_\_ Arterosil: \_\_\_\_\_\_\_\_\_\_ BPC-157: \_\_\_\_\_\_\_\_\_ DIM SGS+ \_\_\_\_\_\_\_\_\_\_\_\_**

**Deep Sleep: \_\_\_\_\_\_\_\_\_ Iodine+ \_\_\_\_\_\_\_\_\_\_\_ Methyl Factors +: \_\_\_\_\_\_\_\_\_ Omega 3 + CoQ10 \_\_\_\_\_\_\_\_\_\_**

**Serene \_\_\_\_\_\_\_\_\_\_\_\_ Senolytic Complex: \_\_\_\_\_\_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**OFFICE USE ONLY**

**– INITIAL PELLET INSERTION FORM MALE**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Labs: \_\_\_\_ Due in 4 weeks \_\_\_\_ Up-to-Date \_\_\_\_\_ Prior to next insertion**

**Prostate Exam: \_\_\_\_\_\_ Prior to next insertion \_\_\_\_\_ Up-to-Date \_\_\_\_ Not Applicable**

**Yearly: \_\_\_\_\_\_ Prior to next insertion \_\_\_\_\_ Up-to-Date \_\_\_\_ Not applicable**

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**-OFFICE USE ONLY –**

**REPEAT PELLET INSERTION FORM MALE**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Weight: \_\_\_\_\_\_ Blood pressure: \_\_\_\_\_\_\_\_\_\_\_\_ Temperature: \_\_\_\_\_\_\_\_\_\_ Activity Level \_\_\_\_\_\_\_

**Current medications**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Procedure note:**

The procedure, risks, benefits and alternatives were explained to the patient. Questions were answered and a consent form for the insertion of testosterone pellet implants was signed. An area was prepped. The area was then infiltrated with local anesthesia. A small incision was made using a #11 blade scalpel. The trocar with cannula was passed through the incision into the subcutaneous tissue. Testosterone 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. Post-insertion instructions were reviewed, and a copy was given to the patient.

**Prep solution:**  \_\_\_\_\_ Alcohol \_\_\_\_\_\_ Chloraprep \_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Local anesthetic**: \_\_\_\_\_ **1% lido w/ep** \_\_\_\_ cc (ml) \_\_\_\_\_\_ **1% lido** \_\_\_\_ cc (ml) other \_\_\_\_\_\_\_\_\_\_\_\_

**Sodium bicarbonate cc: \_\_\_\_\_\_\_\_\_\_**

**Insertion site: \_\_\_\_\_\_\_\_\_ Left hip \_\_\_\_\_\_ Right hip Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**OFFICE USE ONLY**

**– INITIAL PELLET INSERTION FORM MALE-**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treat with:**

**Testosterone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mg Testosterone lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thyroid Rx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ mg daily Probiotic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADK 5 or ADK10: \_\_\_\_\_\_\_\_\_\_\_\_ Arterosil: \_\_\_\_\_\_\_\_\_\_ BPC-157: \_\_\_\_\_\_\_\_\_ DIM SGS+ \_\_\_\_\_\_\_\_\_\_\_\_**

**Deep Sleep: \_\_\_\_\_\_\_\_\_ Iodine+ \_\_\_\_\_\_\_\_\_\_\_ Methyl Factors +: \_\_\_\_\_\_\_\_\_ Omega 3 + CoQ10 \_\_\_\_\_\_\_\_\_\_**

**Serene \_\_\_\_\_\_\_\_\_\_\_\_ Senolytic Complex: \_\_\_\_\_\_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Labs: \_\_\_\_ Due in 4 weeks \_\_\_\_ Up-to-Date \_\_\_\_\_ Prior to next insertion**

**Prostate Exam: \_\_\_\_\_\_ Prior to next insertion \_\_\_\_\_ Up-to-Date \_\_\_\_ Not Applicable**

**Yearly: \_\_\_\_\_\_ Prior to next insertion \_\_\_\_\_ Up-to-Date \_\_\_\_ Not applicable**

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**POST-INSERTION INSTRUCTIONS FOR MEN**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your insertion site has been covered with two layers of bandages. The inner layer is a steri-strip, and the outer layer is a waterproof dressing.

• **Do not take tub baths or get into a hot tub or swimming pool for 7 days**. You may shower, but do not remove the bandage or steri-strips for 7 days.

• No major exercises for the incision area. No heavy lifting using the legs for 7 days. This includes running, elliptical, squats, lunges, etc. You can do moderate upper body work and normal walking on a flat surface.

• 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. If the redness worsens after the first 2-3 days, please contact the office.

• 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 oozing) not relieved with pressure, as this is NOT normal.

• Please call if you have any pus coming out of the insertion site, as this is NOT normal.

• We recommend putting an ice pack on the area where the pellets are located a couple of times for about 20 minutes each time over the next 4 to 5 hours. You can continue this for swelling, if needed. Be sure to place something between the ice pack and your bandages/skin. Do not place ice packs directly on bare skin.

REMINDERS:

• Remember to have your post-insertion blood work done 4 weeks after your FIRST insertion.

• Most men will need re-insertion of their pellets 4-5 months after their initial insertion. If you experience symptoms prior to this, please call the office.

• Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

**Print name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_

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**WHAT MIGHT OCCUR AFTER A PELLET INSERTION (MALE)**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

**INFECTION**: Infection is a possibility with any type of procedure. Infection is uncommon with pellet insertion and occurs in <0.5 to 1%. If redness appears and seems to worsen (rather than improve), is associated with severe heat and/or pus, please contact the office. Warm compresses are helpful, but a prescription antibiotic may also be needed.

**PELLET EXTRUSION**: Pellet extrusion is uncommon and occurs in < 5% of procedures. If the wound becomes sore again after it has healed, begins to ooze or bleed or has a blister-type appearance, please contact the office. Warm compresses may help soothe discomfort.

• **ITCHING OR REDNESS**: Itching or redness in the area of the incision and pellet placement is common. Some patients may also have a reaction to the tape or glue. If this occurs, apply hydrocortisone to the area 2-3 times daily. If the redness becomes firm or starts to spread, please contact the office.

\***FLUID RETENTION/WEIGHT GAIN**: 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, or by taking a mild diuretic, which the office can prescribe.

• **BREAST TENDERNESS OR NIPPLE SENSITIVITY**: These may develop with the first pellet insertion. The increase in estrogen sends more blood to the breast tissue. Increased blood supply is a good thing, as it nourishes the tissue. Taking 2 capsules of DIM daily helps prevent excess estrogen formation. In males, this may indicate that you are a person who is an aromatizer (changes testosterone into estrogen). This is usually prevented if DIM is taken regularly but can be easily treated and will be addressed further when your labs are done, if needed.

**MOOD SWINGS/IRRITABILITY**: These may occur if you were quite deficient in hormones. These symptoms usually improve when enough hormones are in your system. 5HTP can be helpful for this temporary symptom and can be purchased at many health food stores.

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**Print name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_

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**WHAT MIGHT OCCUR AFTER A PELLET INSERTION (MALE) (Continued)**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ELEVATED RED BLOOD CELL COUNT**: Testosterone may stimulate growth in the bone marrow of the red blood cells. This condition may also occur in some patients independent of any treatments or medications. If your blood count goes too high, you may be asked to see a blood specialist called a hematologist to make sure there is nothing worrisome found. If there is no cause, the testosterone dose may have to be decreased. Routine blood donation may be helpful in preventing this.

**• HAIR LOSS OR ANXIETY**: 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. 5HTP may be helpful for anxiety and is available over-the-counter. •

**FACIAL/BODY BREAKOUT**: Acne may occur when testosterone levels are either very low or high. 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.

**• AROMATIZATION**: Some men will form higher-than-expected levels of estrogen from the testosterone. Using DIM 2 capsules daily as directed may prevent this. Symptoms such as nipple tenderness or feeling emotional may be observed. These will usually resolve by taking DIM, but a prescription may be needed.

**• HIGH OR LOW HORMONE LEVELS**: The majority of times, we administer the hormone dosage that is best for each patient, however, every patient breaks down and uses hormones differently. Most patients will have the correct dosage the first insertion, but some patients may require dosage changes and blood testing. If your blood levels are low, results are not optimal and it is not too far from the original insertion, we may suggest you return so we can administer additional pellets or a “boost” (at no charge). This would require blood work to confirm. On the other hand, if your levels are high, we can treat the symptoms (if you are having any) by supplements and/or prescription medications. The dosage will be adjusted at your next insertion.

**• TESTICULAR SHRINKAGE:** Testicular shrinkage is expected with any type of testosterone treatment.

**• LOW SPERM COUNT:** Any testosterone replacement will cause significant decrease in sperm count during use. Pellet therapy may affect sperm count up to one year. If you are planning to start or expand your family, please talk to your provider about other options.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

**Print name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_

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**MALE TREATMENT PLAN**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

• It is best to take these vitamins and/or supplements after eating.

• **If you are currently using another form of testosterone, please stop after 7 to 10 days.**

SUPPLEMENTS: **These are available in our office for your convenience. For best results, please take the supplements recommended for you. Take all supplements or vitamins AFTER a meal.**

\_\_\_\_\_ **DIM SGS+** (take 1 daily)

\_\_\_\_\_ **ADK 5** or \_\_\_\_ **ADK 10** - take 1 daily or as directed

\_\_\_\_\_ **Multi-Strain Probiotic 20B** - take 1 to 2 weekly then increase after 1 month to 1 daily.

\_\_\_\_\_ **Bacillus Coagulans** - take 1 daily or as directed.

\_\_\_\_\_ **Methyl Factors+** - take 1 daily or as directed based on B12 or other lab results.

\_\_\_\_\_\_ **Iodine+** - start by taking 2-3x weekly and gradually increase to daily dosing; start Iodine+ about 4 weeks after your first round of pellets.

\_\_\_\_\_\_ **Arterosil** - take 1 capsule twice daily; take 1 capsule 3x daily if taking for diabetic neuropathy

\_\_\_\_\_\_ **Curcumin SF** - take 1-2 twice daily

\_\_\_\_\_\_ **Omega 3 + CoQ10** - take 1-2 twice daily.

\_\_\_\_\_\_ **Senolytic Complex** - take 1 capsule per day with water or as directed

\_\_\_\_\_\_ **Deep Sleep** - take 2 capsules 30 minutes before bed or as directed.

\_\_\_\_\_\_ **Serene** - take 1 or 2 capsules with water as needed. Effects typically start to diminish after 3-4 hours. Dosing may vary.

\_\_\_\_\_\_ **BPC-157** - take 2 capsules per day with water or as directed.

\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

**Print name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_

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**You & I Primary Care, Aesthetics and Wellness**

1380 NE Miami Garden Drive, Suite 274, Miami, Fl 33179 │ Tel: 954-655-6559 │ Email: [youandimedspa@gmail.com](mailto:youandimedspa@gmail.com)

**MALE TREATMENT PLAN**

PRESCRIPTIONS: These have been called into your preferred pharmacy

\_\_\_\_\_ **NP Thyroid** \_\_\_\_\_\_ mg every morning on an empty stomach; wait 30 minutes before putting anything else on your stomach including coffee, food, or other medications.

\_\_\_\_\_ Wean off **Synthroid/Levothyroxine**: alternate your desiccated thyroid (NP Thyroid or Armour) every other day with Synthroid/Levothyroxine for 3 weeks then go to every day on your desiccated thyroid.

\_\_\_\_\_ **Femara** (letrozole) 2.5 mg \_\_\_\_\_ Tablet every \_\_\_\_\_\_\_ Week (s)

\_\_\_\_\_\_ **Arimidex** (anastrazole) 1 mg \_\_\_\_\_ Tablet every \_\_\_\_\_\_\_ Week (s)

\_\_\_\_\_\_ Wean off your antidepressant (see wean protocol) once you are feeling better in 4-6 week

\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please call or email for any questions about these recommendations.**

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**REQUEST TO RESTRICT DISCLOSURE TO HEALTH PLAN**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth (DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_

Authorized by Section 13405(a) of the HITECH Act

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_request that my treating provider(s) and clinic (listed above) not disclose my protected health information (PHI) to my health plan or other third party insurance carrier. Pursuant to Section 13405(a) of the HITECH Act, I understand I have the right to request restrictions on whether the Practice discloses my protected health information (PHI) with my health plan and the Practice is required to agree to my request unless the information is required to be disclosed to my health plan to comply with the law. The records of the restricted services/items listed below (“Restricted Services/Items”) will not be released or billed to my health plan or other third party insurance carrier for the purposes of payment or health care operations. I understand I am financially responsible for these Restricted Services/Items and will pay out-ofpocket, in full, at the time of service in order for the Practice to accept this restriction request.

REQUESTED RESTRICTION:

Services/Items to be restricted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ subcutaneous pellet hormone replacement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total charge amount (or estimated amount): $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ per treatment/per month (circle one)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am responsible personally for full charges when finalized.

**Print name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_

**Witness name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_

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**ANTIDEPRESSANT WEAN PROTOCOL**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth (DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

If you are taking an SSRI or SNRI antidepressant such as Prozac, Zoloft, Lexapro, Pristiq, Effexor, Viibryd, the generic equivalents or others and have NOT had long-term issues with generalized anxiety disorder, bipolar or major depressive disorders, you may be able to slowly wean off of your antidepressants. We recommend you wean off of these slowly as soon as you start to feel better with your pellets. This is usually after about 4 weeks and only if you are feeling better and ready to start the weaning process. These antidepressants have many side effects. You can feel tired, sleepy, have weight gain or difficulty achieving an orgasm (to name few) which is everything we are trying to improve. It is very difficult for the pellet therapy to have adequate results in some patients who are still on these medications. You are NOT deficient in these antidepressant medications. You are deficient in hormones. As we restore your hormone levels to normal with pellets, your symptoms of anxiety and/or depression should be relieved naturally. You should be able to wean off your antidepressant. Go slowly – especially if you have been taking them for a while. While taking an SSRI or SNRI, your brain relies on these medications to get serotonin (the calming, feel good hormone) and doesn’t make its own. If you stop your medication abruptly, you can go through withdrawals. Symptoms of abrupt cessation may include headache, GI distress, faintness, body aches, chills, and strange sensations of vision or touch. Some patients withdrawing from Effexor may describe the feelings of “electric shocks”. You may also experience depression or anxiety symptoms returning. When you wean slowly, your brain has time to catch up, wake up, and start making its own serotonin again.

If you are on a high-dose or capsule, you may have to request a lower dose to use in the transition.

WE RECOMMEND THE FOLLOWING PROTOCOL TO HELP:

1. Take your pill every other day for 2 weeks.

2. Then every 3 days for 2 weeks.

3. Then every 4 days for 2 weeks and so on until you are down to one a week, then STOP.’

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If at any point you feel badly or “off”, go back to the lowest dose you felt good on and take the wean a bit slower. If you are on a high dose of the medication, you may need an additional prescription for a lower strength so you can slowly transition from the higher to the lower strength and then wean as described above