

# New-Patient Package for Men

*Congratulations! You're on your way toward restoring your vitality.*

Thank you for your interest in BioTE®. Please take the time to read this carefully. You will need to complete the following forms and get labs drawn, in order to determine if you are a candidate for bioidentical hormone pellets. Our medical providers will evaluate this information prior to your consultation to determine if BioTE Medical® can help you live a healthier life.

**Please complete the following 8 tasks:**

- 1) Consider the options for how you will pay for your blood draw**
  - a) Find out if your insurance company will cover the cost, and which lab your insurance company will cover.
  - b) And/or ask your doctor to order the below-mentioned labs.
  - c) If you are uninsured, or you have a high deductible, call our office to schedule a self-pay blood draw. We have negotiated a discounted rate for our patients: \$125.
  - d) Please keep in mind, it can take up to two weeks for your lab results to reach our office.
- 2) Schedule your blood draw** at any Quest Diagnostics, LabCorp, or our office \*at least 2 weeks before your consultation.
- 3) Arrange to get a blood test for the following:**
  - a) Estradiol
  - b) Total Testosterone
  - c) Free Testosterone
  - d) CBC
  - e) Complete Metabolic Panel
  - f) PSA
  - g) TSH
  - h) Total T4
  - i) Free T3
  - j) Thyroid Peroxidase Antibody (TPO)
  - k) Vitamin D, 25-Hydroxy
  - l) Vitamin B-12
  - m) Lipid Panel (a. Optional, b. Not included in the In-House lab price)
- 4) Schedule your personalized Bioidentical Hormone Consultation** - give at least 2 weeks between the time you had your blood drawn and the date of your consult. Call 858-450-1212 to schedule your appointment.
- 5) Complete the “[Male Patient Questionnaire & History](#)”** (see pgs. 2-3)
- 6) Complete the “[Male Testosterone Pellet Insertion Consent Form](#)”** (see pgs. 4-6)
- 7) Complete “[Acknowledgment of Hormone Replacement Fee](#)”** (see page 7)
- 8) Review “[Post-Pellet Insertion Instruction](#)”** (see page 8)

# Male Patient Questionnaire & History

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Name: **(Last)** \_\_\_\_\_ **(First)** \_\_\_\_\_ **(Middle)** \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

May we contact you via e-mail? ☐ YES ☐ NO

In Case of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with Partner ☐ Single

In the event we cannot contact you by the means you've 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.

Partner's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

## **Social:** (select the boxes that apply to you)

- ☐ I am sexually active. ☐ I am no longer wishing to reproduce
- ☐ I want to be sexually active. ☐ My sex-life has suffered.
- ☐ I haven't been able to have an orgasm.
- ☐ Other \_\_\_\_\_

## **Habits:** (select the boxes that apply to you)

- ☐ I smoke cigarettes or cigars. Amount per day: \_\_\_\_\_ [or] Amount per week: \_\_\_\_\_
- ☐ I drink alcoholic beverages. Amount per day: \_\_\_\_\_ [or] Amount per week: \_\_\_\_\_
- ☐ I drink caffeine. Amount per day: \_\_\_\_\_ [or] Amount per week: \_\_\_\_\_

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# Male Patient Questionnaire & History

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## Medical History:

Any known drug allergies: \_\_\_\_\_

Have you ever had any issues with anesthesia? ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

Medications Currently Taking: \_\_\_\_\_

Current Hormone Replacement Therapy: \_\_\_\_\_

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

Nutritional/Vitamin Supplements: \_\_\_\_\_

Surgeries, list all and when: \_\_\_\_\_

## Preventative Medical Care:

Medical exam Date: \_\_\_\_\_ Provider's name: \_\_\_\_\_

## Medical Illnesses:

- |  |   |
|--|---|
| <input type="checkbox"/> High blood pressure                                       | <input type="checkbox"/> Heart bypass                     |
| <input type="checkbox"/> High cholesterol  | <input type="checkbox"/> Testicular &/or prostate cancer. |
| <input type="checkbox"/> Stroke and/or heart attack                                | <input type="checkbox"/> Heart disease                    |
| <input type="checkbox"/> Blood clot and/or a pulmonary emboli                      | <input type="checkbox"/> Arrhythmia                       |
| <input type="checkbox"/> Any form of Hepatitis or HIV                              | <input type="checkbox"/> Arthritis                        |
| <input type="checkbox"/> Lupus or other auto-immune disease                        | <input type="checkbox"/> Thyroid disease                  |
| <input type="checkbox"/> Hemochromatosis: iron overload                            | <input type="checkbox"/> Diabetes                         |
| <input type="checkbox"/> Elevated PSA  | <input type="checkbox"/> Psychiatric disorder             |
| <input type="checkbox"/> Prostate Enlargement                                      | <input type="checkbox"/> Depression/anxiety               |
| <input type="checkbox"/> Trouble passing urine / take Flomax or Avodart            | <input type="checkbox"/> Hypertension                     |
| <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis) |   |
| <input type="checkbox"/> Cancer (type): _____                                      | Year: _____   |
| <input type="checkbox"/> Other _____   |   |

# Male Testosterone Pellet Insertion Consent Form

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Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Bioidentical hormone pellets are hormones, biologically identical to the hormones your testes and adrenal glands produce(d). Bioidentical hormones have the same effects on your body as your own testosterone did when you were younger.

Bioidentical hormone pellets are plant-derived and are FDA monitored. The method of delivering hormones subcutaneously has been used in Europe, Canada and the United States for many years.

**Benefits of testosterone pellet therapy may include:** Increased libido, energy, and sense of well-being; increased muscle-mass, strength, and stamina; decrease in mood swings, decreased anxiety and irritability; decreased weight-gain; decrease in risk, or severity, of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia; decreased risk of heart disease in men less than 75-years-old, with no pre-existing history of heart disease. (On January 31, 2014, the FDA issued a Drug Safety Communication indicating that the FDA is investigating risk of heart attack and death in some men taking FDA approved testosterone products. The risks were found in men over the age of 65, with pre-existing heart disease and men over the age of 75 with, or without, pre-existing heart disease. These studies were performed with testosterone-patches, testosterone creams, and synthetic testosterone injections. It did not include subcutaneous hormone pellet therapy, nor was the testosterone bioidentical as are BioTE's pellets.)

A significant hormonal transition will occur in the first four weeks after the insertion of your hormone pellets. As your body acclimates to its restored hormonal balance, certain changes might develop at the beginning that can be bothersome. The following may/may not occur at first:

- **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.

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# Male Testosterone Pellet Insertion Consent Form

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- **SWELLING OF THE HANDS & FEET:** This is relatively uncommon, but more likely 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.

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

- **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.

- **SCALP HAIR LOSS:** Is rare and usually occurs in patients who convert testosterone to DHT. Dosage adjustment generally reduces or eliminates the problem. We recommend all patients take DIM to counteract this conversion to DHT. Prescription medications for hair loss may be necessary in rare cases.

-Possible side effects from the placement of the pellet itself include, but are not limited to:

Bleeding, bruising, swelling, infection and pain; reaction to local anesthetic and/or preservatives.

-Possible, but rare, side effects from testosterone therapy include, but are not limited to:

Hyper-sexuality (overactive Libido); Lack of effect (from lack of absorption, or extrusion of pellets); Increase in hair growth on the face and body (similar to patterns that occurred in your youth); Growth of liver tumors, if liver tumors are already present; Decreased sperm count, which may negatively affect fertility; Testicular atrophy; Increase in hemoglobin and hematocrit sometimes known as “thickening” of the blood. I agree to stay up-to-date with prescribed blood tests to determine if treatment (blood donation) is required.

**CONSENT FOR TREATMENT:** I consent to the subcutaneous insertion of testosterone pellets in my hip, or any other location deemed appropriate by my provider.

I understand that if I begin testosterone replacement with any testosterone treatment, including testosterone pellets, that I will produce less testosterone from my testicles and if I stop replacement, I may experience a temporary decrease in my testosterone production. It takes 12 months to completely clear the testosterone pellets from my body. In the meantime, my testicles will return to producing their own testosterone at the previous level they were capable of.

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## Male Testosterone Pellet Insertion Consent Form

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I agree to report to my provider any adverse reactions, or problems that may be related to my therapy. Potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications, benefits, and the nature of bioidentical and other treatments and have had all my questions answered. Furthermore, I have not been promised, or guaranteed, any specific benefits from the administration of bioidentical therapy.

I certify this form has been fully explained to me, and I have read it, or have had it read to me, and I understand its contents. I 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 associated with testosterone-therapy that have not been discovered to date. I understand that higher than normal physiologic levels may be reached to create the necessary hormonal balance. I accept these risks and benefits,

**This consent is ongoing for this and all future pellet insertions.**

**Print Name:** \_\_\_\_\_

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

**Today's Date:** \_\_\_\_\_

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## **Acknowledgment of Hormone Replacement Fee**

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. Although more insurance companies are reimbursing patients for the BioTE® Medical Hormone Replacement Therapy, there is no guarantee. 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 can ask for paperwork to send to my insurance company to file for reimbursement should I choose. I acknowledge that Hormonal Wellness of La Jolla, Inc. 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.

**New Patient Consult Fee \$125**

**Male Hormone Pellet Insertion Fee \$800**

**We accept the following forms of payment:**

**Mastercard, Visa, Discover, Personal Checks and Cash. (No AmEx)**

**Print Name:** \_\_\_\_\_

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

**Today's Date:** \_\_\_\_\_

## Post-Pellet Insertion Instructions

- ✘ Your insertion site has been covered with two layers of bandages.
- ✘ The inner layer is a steri-strip. The outer layer is a cotton pad and a waterproof dressing on top of that.
- ✘ On the day of the procedure, we recommend putting an ice pack on the insertion area a couple of times, for 20 minutes each time, over the next 4 to 5 hours. You can continue to ice the site if you have any swelling or discomfort. Be sure to place something between the ice pack and your bandage/skin. Do not place ice packs directly on bare skin.
- ✘ Do not take tub baths or get into a hot tub or swimming pool for 7 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 7 days, this includes running, elliptical, squats, lunges, riding a horse, etc. You can do moderate upper body work and walking.
- ✘ The sodium bicarbonate, in the anesthetic, may cause the site to swell for 1-3 days. This is normal.
- ✘ If there is itching or redness you may take Benadryl for relief, 50 mg. orally every 6 hours. Caution this can cause drowsiness, so use your judgement.
- ✘ You may experience discomfort, bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- ✘ If you experience bleeding from the incision, apply firm pressure for 5 minutes. You may notice some pinkish or bloody discoloration on the outer bandage. This is normal. Please call if you have any bleeding (not oozing) that is not relieved by pressure, since this is NOT normal.
- ✘ Please call if you have any pus coming out of the insertion site, as this is NOT normal.
- ✘ Please call to make an appointment to get your labs drawn 4 weeks from the date you were pelleted.
- ✘ Please call to make an appointment to get your next pellets as soon as symptoms that were relieved from the pellets start to return. (Most men will need their next pellets 5-7 months after their last insertion.)