New Creation MediCosmetic Centre
(905)937-9559
newcreationmedicosmetic@gmail.com

BHRT & TRT Patient Consent Form
For services rendered by Dr. Kelada Sedra

As a patient, I have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed so I may make the decision to give or withhold my consent as to whether or not to undergo care. After thorough discussion of potential benefits, risks and hazards involved with proposed treatment modality

I further understand that Dr.Kelada-Sedra is not my primary care physician. I seek her counsel for cardiometabolic, health, and wellness optimization and preventative measures. These services are not covered by OHIP.

I understand that bioidentical hormone replacement therapy (BHRT) is the therapeutic use of hormones generally used to treat the following; however, is not limited to: PMS, perimenopause, menopause, andropause, thyroid dysfunction, adrenal fatigue, and other symptoms of chronic disease can also be addressed.

I understand I am engaging in preventative care that is not covered by the Ontario Health Insurance Plan (OHIP) therefore, will incur out-of-pocket costs to be paid by myself (the patient). Check with your private insurance

It is my responsibility to have an annual exam, PAP, and mammography according to guidelines and advise the provider of any pertinent findings.

For women this includes the following (please initial):

- ☐ PAP testing every 3 years until age 65 _____
- ☐ Mammography every 2 years or recommended interval _____
- ☐ Colon cancer screening _____

For men this includes the following:

- ☐ Digital rectal exam yearly _____
- ☐ Colon cancer screening _____

_____

I understand there is no guarantee to treatment. I further understand that lifestyle modification, nutrition, weight management, adequate sleep and stress reduction are important factors to the success of HRT

I understand I can request further explanation of the procedure or treatment, alternative treatment options/methods of treatment, and/or information about the material risks of the procedure or treatment.

It is my responsibility to keep Dr. Kelada-Sedra up to date with all of the current medications and supplements that I am taking so that she can make the best informed recommendations for my care. It is also my responsibility to keep Dr. Kelada-Sedra up to date with any changes in my health that occurs between assessments. I understand a change in my health can significantly change the risk versus benefit associated with a treatment, and therefore may lead to discontinuation of treatment where it is felt it puts me at unnecessary risk to continue. Dr. Kelada-Sedra reserves the right to discontinuation of care if a routine follow-up is not maintained (every 3 months).

It is my responsibility to advise Dr. Kelada-Sedra of any surgery and be aware, that when possible hormone therapy will be held 5 days prior to surgery. Hormone therapy will not reinitiated until Dr. Kelada-Sedra directs me to do so.

Initial:_____

I have the opportunity to ask questions and discuss with Dr. Kelada-Sedra to my satisfactions:

- my suspected diagnosis or condition
- the nature, purpose, and potential benefit of the proposed care
- the inherited risks, complications, potential hazards or side effects of the treatment or procedure
- the probability or likelihood, of success
- reasonable available alternatives to the proposed treatment or procedure
- the possible consequences if treatment or advice is not followed and/or nothing is done.

I am aware my personal health information will be collected for purposes of diagnostic services and treatment in a secure medical record which meets the requirements as require by the Personal Health Information Protection Act. I understand that when required, Dr. Kelada-Sedra may discuss my case with other health professionals in order to provide integrative and continuous care. I understand I may request to see my file at any time and may request a copy of my file.

I acknowledge that a message may be left on voicemail/answering machine or by e-mail in order to advise me of relevant information regarding my appointment.
With my signature, I consent to Dr. Kelada-Sedra and agents and staff acting on behalf of New Creation MediCosmetic Centre to contact me and leave a message, email me, or text regarding my appointments.

By signing this form, I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by Dr. Kelada-Sedra

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I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment and I may ask my Dr. Kelada-Sedra for a more detailed explanation. I understand I may withdraw my consent and request additional information as needed. I understand BHRT is not a substitute for primary care.

PRINT PATIENT NAME: _____

SIGNATURE OF PATIENT: _____

DATE: _____

Fee schedule

patient initials
_____

1st Consult (45mins) $350.00 - includes a written care plan
Follow up appointments (every 3 months) $225.00
If you run out of your hormones and require a prescription refill the fee is $50.00

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Medical History and Screening

General Information

HOST CLINIC IF PATIENT REFERRED TO NEW CREATION MEDICOSMETIC CENTRE BY ANOTHER CLINIC ______________________________

REFERRING PRACTITIONER ;;______________

Participant/ Patient:

Full name ______________________________

Address ______________________________

Home Tel# ______________________ Cell# ______________

Email ______________________________

Birth date ______________________________

OHIP# and Expiry ______________________

Name of Family Physician and/or Primary Health Care Provider: ______________ Phone ______________

Address ______________ City ______________

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

Yes ☐ No ☐

Patient Signature: ______________________________

Marital Status:

Single ☐ ☐ Married ☐ Common Law ☐ Divorced ☐ Widowed

Gender:

Male ☐ Female ☐ ☐ Transgender ☐ Other

Occupation: ______________________________

Medical History

Height: _____

Weight: _____

Blood Pressure: _____(if you cannot remember your latest BP please request when you pick up your prescription)

Please indicate conditions or procedures YOU have had done in your life:

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Heart disease
- ☐ Elevated cholesterol or triglycerides
- ☐ Varicose veins
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Nervous or emotional problems
- ☐ Mental health
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Liver disease
- ☐ Autoimmune disorders
- ☐ Genetic disorders
- ☐ Osteoporosis
- ☐ Deep Vein Thrombosis

List any prescription medications you are now taking: _____

_____

_____

List any hormone medications you are currently taking: _____

_____

_____

List any self-prescribed medications, dietary supplements, or vitamins you are now taking: _____

_____

_____

List any other medical or diagnostic test you have had in the past two years: _____

_____

List hospitalizations, including dates of and reasons for hospitalization: _____

_____

_____

List any drug allergies: _____

Do you have any environmental allergies? _____

Women only

Date of the last pelvic exam and / or Pap smear _____

Date of last mammography/breast ultrasound _____

Total Number Pregnancies: _____ vaginal____ or C-Section____

Total Live Births: _____

Live Children: _____

Total Miscarriages (Spontaneous/Therapeutic): _____

Age started Menses: _____

Date of last menstrual period: _____

Do you have:

- ☐ Menstrual period problems
- ☐ Significant childbirth - related problems
- ☐ Urine loss when you cough, sneeze or laugh?
- ☐ Have you ever had an abnormal PAP?
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Ovarian cysts
- ☐ Cervical or endometrial cancer
- ☐ PCOS

For Men Only

Do you have a history of prostate cancer or testicular cancer? Yes ☐ No ☐

Do you have a family hx of prostate cancer or testicular cancer? Yes ☐ No ☐

Who: _____

Have you ever had an abnormal PSA, what was the value? Yes ☐ No ☐

Value:_____

Have you had an abnormal ultrasound of prostate? Yes ☐ No ☐

Family Medical History

Father:

Alive ☐ Current age _____

My father's general health is:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Reason for poor health _____

Deceased ☐ Cause_____

Alive ☐ Current age _____

My mother's general health is:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Reason for poor health: _____

Deceased ☐ Cause of death: _____

Siblings: Number of brothers _____ Number of sisters _____ Age Range _____

Health problems _____

Familial Diseases

Have any relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave others blank).

- ☐ Heart attacks under age 50
- ☐ Strokes under age 50
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Asthma or hay fever
- ☐ Congenital heart disease (existing at birth but not hereditary)
- ☐ Heart operations
- ☐ Glaucoma
- ☐ Obesity (20 or more pounds overweight)
- ☐ Leukemia or cancer underage 60
- ☐ Deep vein thrombosis
- ☐ Breast cancer
- ☐ Prostate cancer
- ☐ Endometrial cancer
- ☐ Genetic disorders
- ☐ Hormone disorders
- ☐ Osteoporosis

Comments: _____

_____

_____

_____

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Smoking

Have you ever vaped, smoked cigarettes, cigars or a pipe?

Yes ☐ No ☐

If you did or now smoke cigarettes/vape, how many per day? _____ Age started _____

If you did or now smoke cigars, how many per day? _____ Age started _____

If you did or now smoke a pipe, how many pipefuls a day? _____ Age started _____

If you have stopped smoking, when was it? _____

If you now smoke, how long ago did you start? _____

Alcohol

Do you ever drink alcoholic beverages?

Yes ☐ No ☐

At any time in the past, were you a heavy drinker (consumption of six ounces of hard liquor per day or more)?

Yes ☐ No ☐

How many alcohol drinks do you have weekly? _____

Have you used illicit drugs? _____

Comments: _____

_____

_____

Sleep

How much sleep are you getting each night on average? _____

Are you feeling well rested in the am? Yes ☐ No ☐

Do you need a nap midday? Yes ☐ No ☐

Do you snore or do you have sleep apnea? Yes ☐ No ☐

Do you use CPAP machine? Yes ☐ No ☐

Foods

Do you follow any particular style of eating (keto, low carb, vegan etc)

_____

Do you know of any food sensitivities you have:

_____

Please briefly explain the main symptoms you are experiencing:

_____

_____

_____