Informed Consent for Hormone Treatment-Oestrogen

Name in Full: DOB:
Address:

I agree that I have had the implications of having Oestrogen therapy explained to me in full by
Dr …….
I have had the opportunity to discuss the effects of hormones with my doctor, and to clarify any points I did not understand.
I have had this for an adequate time to read it and discuss it with my doctor

Effects of Oestrogen
As a result of taking oestrogen I expect to experience:

- Some breast growth
- Some redistribution of body fat to approximate to a female pattern
- Decreased upper body strength
- Softening of the skin
- A modest decrease in body and facial hair
- A slowing of the loss of scalp hair
- Decreased testicular size and less frequent and less firm erections
- Reduced libido
- Decreased fertility. I may become permanently infertile after prolonged treatment. I have considered my options regarding sperm storage. I understand that if I have not stored sperm prior to commencing oestrogen, then I may not be able to do so later because of irreversible infertility.

I understand that most of these changes are reversible but breast enlargement, which will occur slowly over a period of up to 2 years, will not completely reverse if oestrogen is stopped. Where this is the case, the remaining breast tissue can only be removed surgically.

Potential Risks and Side Effects
I understand that the most likely side effects are:

- Nausea
- Headaches/Migraines

Less Common but Potential Side Effects include

- Venous thrombosis (blood clot in vein of leg)
- Pulmonary embolism (blood clot in lung)
- Benign pituitary prolactinoma (non malignant brain tumour)
- Weight gain
- Mood swings
- Liver disease
- Gallstones
- High blood pressure
- Diabetes mellitus

I understand that I will be at increased risk of unwanted side effects if any of the following pre-existing factors apply:

- Cigarette smoking
- Obesity
- Alcohol and/or drug abuse
- Advanced age

I understand that a lifelong maintenance dose of oestrogen is almost certain to be required even after genital surgery.

I agree to take the hormones in the dosage prescribed by my doctor and undertake not to take additional doses of oestrogen as this will pose an extra health risk.

I understand that other medication available on or off prescription may interact with my hormone treatment, and I will discuss this with my doctor before taking any new medication or herbal treatments.

I agree to my hormone treatment being monitored by my doctor.

I am 18 years of age or older.

Signed ……...Date……..

I, Dr ……..am satisfied that ……
understands the nature of the proposed treatment and has a full appreciation of the consequences of both the treatment in terms of intended and possible side effects and also the consequences of not following this treatment.

Signed……Date……