PATIENT CONSENT FOR OFF-LABEL MEDICATION USE

Patient Name: ________________________________
Date of Birth: ________________________________
Medication Name: ________________________________
Condition Being Treated: ________________________________

I, ________________________________, hereby acknowledge that my healthcare provider, Dr. ________________________________, has recommended the use of the medication listed above for a purpose or at a dosage that has not been specifically approved by the Food and Drug Administration (FDA). This is known as "off-label" use.

By signing this form, I confirm the following:

- My physician has explained that while the medication is FDA-approved for other conditions, it is not specifically labeled for my current diagnosis.
- The reasons for using this medication off-label have been explained to me, including the potential benefits compared to other available treatments.
- The potential risks, side effects, and uncertainties associated with this off-label use have been discussed.
- I understand that I have the right to refuse this treatment and have been informed of alternative treatment options.
- I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.

I voluntarily consent to the use of this medication as part of my treatment plan.

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Patient/Legal Guardian Signature

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Date

____
Physician Signature

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Date