CALIFORNIA HAIR AND SKIN INSTITUTE

INFORMED CONSENT FOR FINASTERIDE FOR HAIR LOSS TREATMENT

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date: _____

Treating Physician: Vakas Sial, MD

PURPOSE OF THIS CONSENT

This document explains the benefits, risks, alternatives, and limitations of Finasteride therapy for hair loss.

Please read this document carefully and ask any questions before signing.

---

1. NATURE OF THE MEDICATION

I understand that Finasteride is a prescription medication used to treat male pattern hair loss (androgenetic alopecia).

Finasteride works by reducing levels of dihydrotestosterone (DHT), a hormone associated with hair follicle miniaturization and hair loss.

I understand:

- Finasteride is FDA-approved for male pattern hair loss.
- Results may take several months to become noticeable.
- Continued treatment is generally required to maintain benefits.
- Hair loss may resume after discontinuation.

---

2. EXPECTED BENEFITS

Potential benefits may include:

- Slowing progression of hair loss
- Maintaining existing hair
- Improving hair density in some patients

I understand that individual results vary and improvement cannot be guaranteed.

---

3. RISKS AND POSSIBLE SIDE EFFECTS

Possible side effects include:

- Reduced libido
- Erectile dysfunction
- Decreased ejaculatory volume
- Breast tenderness or enlargement
- Depression or mood changes
- Testicular discomfort
- Allergic reaction

Persistent sexual side effects have been reported by some individuals, although causation remains under study.

---

4. PREGNANCY WARNING

Women who are pregnant or may become pregnant should not handle crushed or broken Finasteride tablets because of potential risk to a developing fetus.

---

5. ALTERNATIVES

Alternative treatments may include:

- No treatment
- Hair transplantation
- PRP therapy
- Minoxidil
- Dutasteride
- Low-level laser therapy
- Hair camouflage products
- Observation

---

6. NO GUARANTEE OF RESULTS

I understand:

- Medicine is not an exact science.
- Hair growth and response to treatment vary among individuals.
- No guarantees have been made regarding results.
- Additional treatments may be recommended.

---

7. QUESTIONS AND CONSENT

I certify that:

- I have had sufficient opportunity to ask questions.
- My questions have been answered to my satisfaction.
- I understand the benefits, risks, alternatives, and limitations of Finasteride therapy.
- I voluntarily consent to treatment.

PATIENT CONSENT

I authorize Dr. Vakas Sial and the California Hair and Skin Institute clinical team to prescribe and manage Finasteride therapy when medically appropriate.

Patient Signature: _____

Printed Name: _____

Date: _____

PHYSICIAN CERTIFICATION

I certify that I have discussed the nature of the medication, anticipated benefits, material risks, alternatives, and answered the patient's questions.

Physician: Vakas Sial, MD

Signature: _____

Date: _____