CALIFORNIA HAIR AND SKIN INSTITUTE

INFORMED CONSENT FOR DUTASTERIDE 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 Dutasteride therapy for hair loss.

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

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1. NATURE OF THE MEDICATION

I understand that Dutasteride is a prescription medication that inhibits both Type I and Type II 5-alpha reductase enzymes, reducing conversion of testosterone to dihydrotestosterone (DHT).

I understand:

- Dutasteride use for hair loss is considered **off-label in the United States**.
- My physician has discussed why Dutasteride may be recommended.
- Alternative treatments have been explained.
- Benefits cannot be guaranteed.

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2. EXPECTED BENEFITS

Potential benefits may include:

- Slowing progression of hair loss
- Supporting maintenance of existing hair

- Improving hair density in some patients

I understand individual results vary.

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3. RISKS AND POSSIBLE SIDE EFFECTS

Possible side effects include:

- Reduced libido
- Erectile dysfunction
- Ejaculatory disorders
- Breast tenderness or enlargement
- Depression or mood changes
- Allergic reactions

Persistent sexual side effects have been reported by some individuals.

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4. PREGNANCY WARNING

Women who are pregnant or may become pregnant should not handle broken Dutasteride capsules because of potential fetal risk.

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5. ALTERNATIVES

Alternative treatments may include:

- No treatment
- Finasteride
- Minoxidil
- PRP therapy
- Hair transplantation
- Low-level laser therapy
- Observation

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6. NO GUARANTEE OF RESULTS

I understand:

- Medicine is not an exact science.
- Results vary among individuals.
- No guarantees have been made regarding treatment outcomes.

PATIENT CONSENT

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

Patient Signature: _____

Printed Name: _____

Date: _____

PHYSICIAN CERTIFICATION

Physician: Vakas Sial, MD

Signature: _____

Date: _____