Updated on 10/21/2019

Sildenafil & Tadalafil Patient Consent Form

Patient MRN#_____ Prescribing Provider: _____

Uropartners Dispensary is pleased to offer Sildenafil and Tadalafil to our patients.

I, _____, hereby give authorization to charge my credit card for $90.00 to my Urologist for the cost of medication. The risks and benefits have been explained to me by my provider to my satisfaction. Furthermore, I have received literature and have been provided education material on the medication chosen below. I choose the following medication and dosage:

- ☐ Sildenafil 20 mg tablets, 90 tabs
- ☐ Tadalafil 5 mg tablets, 90 tabs
- ☐ Tadalafil 20 mg tablets, 30 tabs

I understand the benefits and risks to treatment including any side effects. I acknowledge that all sales are final. I also understand that I have been offered the opportunity to fill this prescription at an outside pharmacy of my choice.

Other Information –

Take your medication exactly as directed and written on your prescription label. By FDA law, this medication is not for resale nor can it be returned for refund. Do not let anyone else take your medication. This medication is intended for use solely by the person for whom it is prescribed and should not be shared with any other individuals.

Please follow the directions on your prescription label carefully. If you need further explanation or have questions, please ask your Urologist to explain any part you do not understand.

If you have any questions or need a refill, please contact our Uropartners Dispensary at (224) 260-3100 between the hours of 8 am to 4 pm. **In the case of an emergency, you need to call 911 or go to your nearest emergency room.**

Shipping Information:

You will receive your medication in the mail via FedEx over the next 3-5 business days and a direct signature is required.

-One time complimentary shipping
-Reshipping charges will be applied ($15.00)
-Text message will be provided by FedEx when shipping with tracking number

Preferred shipping address (No PO Boxes) _____

Cell phone preferred (for delivery notice) _____

I certify that I have read this agreement and my signature indicates my understanding and consent.

_____ _____
Patient Name (Please Print) **Patient Date of Birth**

_____ _____
Patient Signature **Date**