specialists in gastroenterology

Domperidone Consent Form

Domperidone is a medication used to speed up emptying of stomach by increasing the movements and contraction of stomach This medication is able to be specially made at a few compounding pharmacies (in Illinois or Canada). It is available over the counter in Europe but never went through the process of seeking FDA approval in the US and therefore can not be purchased through a regular pharmacy

Some potential side effects are: headache, dizziness, dry mouth, nervousness, flushing, or irritability may occur the first several days as your body adjusts to the medication. Trouble sleeping, stomach cramps, hot flashes and leg cramps have also been reported. If any of these effects continue or become bothersome, inform your doctor. Notify your doctor immediately if you develop: chest pain, slow/fast/irregular heartbeat, swelling of the feet or ankles, difficulty urinating, swelling of the breasts or discharge from the nipple in men or women, menstrual changes, sexual difficulties. If you notice other effects not listed above, contact your doctor or pharmacist.

Domperidone can potentially alter the EKG and put you at risk for ventricular arrythmias. This primarily is a risk when it is taken with other medicines which can alter the EKG. While on Domperidone you must agree to have an EKG every 6 months to make sure your "QTc" interval remains normal.

If you agree to take Domperidone you will receive the list of medications to avoid taking with Domperidone. Your physician will give you this list separately if he or she decides Domperidone is an appropriate medication for you. It is your responsibility to review this list with your list of medicines that you take at home now and in the future.

By signing the following you understand the following:
I understand the reason for the use of Domperidone. I understand the risks and possible side effects, as outlined above. I agree to take the medication as directed, and follow up with my doctor or PA as directed. I agree to inform my doctor or PA immediately if I experience any of the side effects described above. I agree to proceed with treatment.

Print_____ Date of Birth: _____

Sign_____ Date_____

11525 Olde Cabin Road Creve Coeur, Missouri 63141 www.GIdoctor.net
Phone 314.997.0554 fax 314.997.5086