

ROSIGLITAZONE
Patient Informed Consent

My doctor has recommended a drug that contains ROSIGLITAZONE to treat my diabetes.

Please read this Patient Informed Consent (“Consent”) and the individual Consumer Information for the prescribed drug containing ROSIGLITAZONE. Discuss any questions or concerns with your doctor before you sign this Consent.

Do not sign this Consent and do not take a drug containing ROSIGLITAZONE if there is anything you do not understand about the information you have received.

I am aware that:

- ROSIGLITAZONE is a medicine used in addition to diet and exercise to lower blood sugar in people with type 2 diabetes when all other diabetes medicines taken orally (by mouth), either alone or in combinations, have not lowered blood sugar enough or are not appropriate.
- Rosiglitazone may increase the risk of serious heart problems, including:
 - heart failure
 - angina (chest pain)
 - heart attack (myocardial infarction)
 - fluid retention (with or without weight gain)
- ROSIGLITAZONE should not be used if I have or have had heart problems.
- There are other options to treat my diabetes, as explained by my doctor.
- There are other risks associated with ROSIGLITAZONE that are outlined in the individual Consumer Information for drugs containing ROSIGLITAZONE and I have been given the opportunity to ask and discuss any questions or concerns about those risks with my doctor.
- I understand that in order to be prescribed a drug containing ROSIGLITAZONE, I am required to sign this Consent.

My doctor has explained the above to me, I have been given time to read this Consent and the individual Consumer Information for the prescribed drug containing ROSIGLITAZONE carefully, and to discuss it with my doctor.

I now authorize my doctor to continue/begin my treatment with ROSIGLITAZONE.

Patient or Legally Appointed Guardian signature lines are below.

ROSIGLITAZONE is not recommended for use in people under the age of 18.

Patient (and Legally Appointed Guardian if applicable) Name(s)

Please Print: _____

Patient / Legally Appointed Guardian Signature:

Date _____