Weight Loss Treatment Consent

This document is intended to serve as a confirmation of informed consent for compounded Semaglutide/Tirzepatide, which are prescription weight management medications.

Do not take this medication if:

You have a personal or family history of medullary thyroid carcinoma (Thyroid Cancer)

You have a personal history Multiple Endocrine Neoplasia syndrome type 2 (MEN2)

You are pregnant or plan to become pregnant while taking this medicine

You are diabetic and/or taking any medications related to lowering your blood sugar levels without speaking with your endocrinologist or primary care provider. Specifically, if you are prescribed Insulin because the combination may increase your risk of hypoglycemia (low blood sugar) and dosage adjustments by your provider may be necessary.

You are allergic to Semaglutide/Tirzepatide or any other GLP-1 agonist such as: Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy® (THIS IS NOT AN ALL-INCLUSIVE LIST)

Patient Informed Consent

I voluntarily request that Dr Thuan Dao and NP Thanh Nguyen (providers) treat my medical condition.

I have informed my provider of any known allergies, medical conditions, medications, social/family history.

I have the right to be informed of any alternative options, side effects, and the risks and benefits.

I understand the prescription will come from a compounding pharmacy.

I understand the mechanism of action of the medication and how it is to be administered.

Prices may vary and change. Dr Thuan Dao and NP Thanh Nguyen (provider) may change the pharmacy based on several factors (availability, shipping time, cost).

It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.

I understand this medication may cause adverse side effects (see below). I understand this list is not complete and it describes the most common side effects.

Common side effects include, but are not limited to:

Gastrointestinal: Nausea/vomiting, abdominal pain, diarrhea/constipation, flatulence, gastroenteritis, GERD, gastritis, lipase increase, amylase increase, headache, dizziness, hypotensive, hypoglycemia, redness or pain at injection site.

Uncommon and serious side effects include, but are not limited to : hypersensitivity reaction, Anaphylaxis, Angioedema, Acute kidney injury, Chronic renal failure exacerbation, Pancreatitis, Cholelithiasis, Cholecystitis, Syncope,Thyroid C-cell tumor (animal studies), Medullary thyroid cancer.

I understand that I have the following responsibilities:

I agree to obtain prescriptions for compounded Semaglutide (or Tirzepatide) only from the provider.

Dr Thuan Dao and NP Thanh Nguyen (provider) may ask to review, with your permission, your medical history (medications, recent lab results, pertinent imaging results).

I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.

I will be honest to the best of my ability regarding my history.

I will tell my provider any updated health information (medication, allergies, personal medical issues/surgeries/social history, or family history changes).

My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider

The provider may ask for me to seek additional labs while on treatment to ensure its safety.

Directions for use: I will take my medications only as prescribed according to the directions.

If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions.

I will not adjust my medications without prior instruction to do so. I understand this medication must be self-injected in the subcutaneous tissue once weekly.

I will not share needles and dispose of needles safely.

If I'm having troubles with the administration of the medication, I will seek help from the provider.

I am the only one who will use my medication. I will not give or sell my medication to anyone else.

If the provider deems it appropriate to start weaning my medication or transition to maintenance dosing, I will comply.

Discontinuation of medication: I understand that the provider may stop prescribing my medications if: a. I am having unfavorable side effects or it's not working to treat my medical condition b. I have been untruthful in my medical or family history c. I do not follow through with the recommended plan of care set by provider d. I do not follow the provider's instructions.

Report adverse side effects to your clinician. In the event of any emergency, call 911 immediately.

I have read this form. I fully understand the above information and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

My signature signifies that I have been offered and have had the opportunity to review the HIPAA disclosure form.

Full name : _____

Signature : _____ Date : _____