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This document is intended to serve as a confirmation of informed consent for compounded semaglutide or tirzepatide, which is a prescription weight management medication.

A. Patient Informed Consent

1. I voluntarily request that my provider treats my medical condition.
2. I have informed my provider of any known allergies, my medical conditions, medications, social/family history.
3. I have the right to be informed of any alternative options, side effects, and the risks and benefits.
4. I understand the mechanism of action of the medication.
5. I understand how it is to be administered.
6. I understand the prescription will come from a compounding pharmacy, which is not FDA approved. I have been told that the manufacturing facility itself is FDA monitored along with third party testing on the medication itself.
7. Prices may vary and change.
8. It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.
9. 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, and that death is also a possibility of taking this medication. I understand symptoms may be worse after there has been a change in my medication dose or when first starting the medication.
   a. **Common side effects include, but are not limited to:**
      (i) Gastrointestinal: Nausea/vomiting, abdominal pain, diarrhea/constipation, dyspepsia, abdominal distension, eructation, flatulence, gastroenteritis, GERD, gastritis, lipase increase, amylase increase
      (ii) Neurological: Headache, dizziness
      (iii) Cardiac: Heart rate increase, Hypotension
      (iv) Endocrine: Fatigue, hypoglycemia (diabetic patients), alopecia
      (v) Ophthalmic: Retinal disorder (diabetic patients)
      (vi) *Skin: redness or pain at injection site*
   b. **Serious Reactions include, but are not limited to:**
      (i) Thyroid C-cell tumor (animal studies)
      (ii) Medullary thyroid cancer
      (iii) Hypersensitivity reaction
      (iv) Anaphylaxis
      (v) Angioedema
      (vi) Acute kidney injury
      (vii) Chronic renal failure exacerbation
      (viii) Pancreatitis
      (ix) Cholelithiasis
      (x) Cholecystitis

(xi) Syncope

B. Patient Responsibilities:

1. Medical history
   a. I will provide my complete medical history, including: allergies, medications, medical/surgical/social/family history.
   b. The provider may ask to review, with your permission, your medical history (medications, recent lab results, pertinent imaging results).
   c. I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.
   d. I will be honest to the best of my ability the history she needs to know.
   e. I will tell my provider any updated health information (medication, allergies, personal medical issues/surgeries/social history, or family history changes).
   f. My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider.
   g. I will always tell other providers about all medications I am taking.
   h. My provider may ask for me to seek additional labs while on treatment to ensure it's safety.
2. Directions for use
   a. I will take my medications only as prescribed according to the directions.
   b. If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions.
   c. I will not adjust my medications without prior instruction to do so.
   d. I understand that the medication must be either kept frozen or refrigerated.
   e. I understand this medication must be self-injected in the subcutaneous tissue once weekly. I will not inject any less than 7 days unless directed by my provider (example: travel).
   f. I will not share needles and dispose of needles safely.
   g. If I'm having troubles with the administration of the medication, I will seek help from my provider.
   h. The medication expires after 12 weeks. I will refer to the Beyond Usage Date (BUD).
3. Safety
   a. I understand it is important to keep my medication away from children (<18 years old).
   b. I am the only one who will use my medication. I will not give or sell my medication to anyone else.

C. Discontinuation of medication:

1. I understand that my 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 Colleen.
   d. I do not follow any parts of "section B: Patient responsibilities" in this agreement.

I have read this form in its entirety. It has been explained to me. I have had the opportunity to ask questions and have all my questions answered. 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.