GLP-1: CONSENT FORM

This document is intended to serve as confirmation of informed consent for compounded Glucagon-like Peptide-1 (GLP-1) Injections (semaglutide, tirzepatide, or other), which are prescription medications used for weight loss.

DO NOT take this medication if you:

- Have a personal or family history of Medullar Thyroid Carcinoma (thyroid cancer)
- Have Multiple Endocrine Neoplasia Syndrome Type 2
- Have a history of pancreatitis
- Are pregnant, plan to become pregnant, or are breastfeeding
- Are allergic to Semaglutide, Tirzepatide, BPC-157, or any other GLP-1 Agonist

Possible Side Effects: Nausea, Vomiting, Diarrhea, Constipation, Abdominal Pain, Headache, Fatigue, Dyspepsia, Dizziness, Abdominal Distention, Belching, Hypoglycemia, Flatulence, Gastroenteritis, Gastroesophageal Reflux Disease, Injection Site Reactions (itching or burning at site of administration with/without thickening of the skin)

A serious allergic reaction to this medication is rare. Seek medical attention if you experience symptoms such as rash, itching/swelling (especially of the throat), severe dizziness, or trouble breathing.

Directions for use:

- I understand this medication must be self-injected in the subcutaneous tissues once weekly
- I understand this medication must be kept refrigerated and expires after 28 days of puncture
- I will notify my provider If I experience side effects or if I am having trouble with administration
- I will not share this medication (or needles) with others and agree to dispose of needles safely

PATIENT CONSENT:

I have informed my provider of all medical conditions, any known allergies to drugs or other substances, and any past adverse reactions I've experienced. I have informed my provider of all medication and supplements I am currently taking. I understand this prescription comes from a compounding pharmacy and is not FDA approved. I have been informed that the manufacturing facility is FDA-monitored and the medication is third party tested. I understand that these medications are not generic versions of the commercially available brand named GLP-1s and Carolina Pharmacy makes no claims for our compounded products to be the equal, bioidentical, or generic versions of the commercially available brand name GLP-1s (Ozempic, Wegovy, Mounjaro, Zepbound, or other). I am aware of the possible side effects. I understand this medication could be harmful if taken inappropriately and should be used only as prescribed. I acknowledge that no guarantees have been made to me concerning my results.

I certify that I have read the contents of this form in its entirety. I have watched the training video and understand how to use the medication. I have had the opportunity to ask questions and have had my questions answered. I fully understand the contents of this form and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

_____	_____	_____/_____/_____
Full Name (please print)	*Signature*	*Date*

SEMAGLUTIDE: CONSENT FORM

PATIENT INFORMATION:

First Name: _____ Last Name: _____

Date of Birth: _____ Gender (circle): Male Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: ( ) _____ Email: _____

MEDICAL HISTORY:

Do you have a personal history of: ☐ Pancreatitis ☐ Hypoglycemia ☐ No

Do you have a personal OR family history of: ☐ Thyroid Cancer ☐ Endocrine Disorder (MEN 2) ☐ No

Are you pregnant or planning to become pregnant: ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

PATIENT CONSENT:

I understand that it is not possible to predict all possible side effects or complications associated with using sublingual semaglutide. I understand the risks/benefits associated with sublingual semaglutide and have received, read, and/or had explained to me any information pertaining to the sublingual semaglutide compound(s) I may be prescribed. I confirm that I am not pregnant nor breastfeeding and will not hold Carolina Pharmacy responsible for usage of this medication if pregnant or breastfeeding.

On behalf of myself, my dependents, and/or my personal representatives, I hereby release and hold harmless Carolina Pharmacy, its staff, and any of its subsidiaries from all liabilities or claims, whether known or unknown, arising out of, in connection with, or in any way related to the sublingual semaglutide compound(s) I am prescribed.

I agree to be fully financially responsible for the full cost of the sublingual semaglutide compound(s). I understand that payment is due prior to consultation, examination, and dispensing of the medication. I understand that the sublingual semaglutide compound can take weeks to months to see noticeable effects (or may have no effect at all) and I will not be issued a refund for any reason whatsoever once I have agreed to these terms and have made payment.

I have read and agree to the terms above.

_____ _____ _____/_____/_____

Full Name (please print) *Signature* *Date*

STAFF USE ONLY

Patient Identifier: _____ Scanned in Profile? ☐ Staff Initials: _____