**Semaglutide therapy consent**

I, , DOB

By signing this consent form, attesting that I read and understood the facts, indications, contraindications, and side effects of Semaglutide. I understood that:

1- Semaglutide is a weekly subcutaneous injection that
◯ I prefer to self-administer it once weekly per the scheduled dose determined by my physician or
◯ Having the Practice staff to administer it once weekly per the scheduled dose determined by my physician.

2- I understood the important warnings for this medication as follow:
In rodents, Semiglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures. It is unknown whether Semiglutide causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans as human relevance of Semiglutide-induced rodent thyroid C-cell tumors has not been determined. Semiglutide is contraindicated in patients with a personal of family history of MCT or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). I understood the potential risk of MTC with use of Semiglutide and will inform my doctor in case of having symptoms of thyroid tumors (e.g. a mass in the neck, difficulty to swallow, shortness of breath and persistent hoarseness).
3- I had the opportunity to ask questions and received satisfied answers before opting to participate in the Semaglutide therapy.
4- I understood that the shelf life of the Semaglutide vial provided to me is 45 days from manufacturing data and I am responsible to keep it per provided instructions and do not use any leftover if it is expired.

PRINT YOUR FULL LEGAL NAME:

Signature:

Date: