

INFORMED CONSENT SELF-ADMINISTRATION OF INJECTABLE MEDICATION AT HOME

Phi Clinic – Weight Management & Wellness Program

Patient Name:

Date of Birth:

Phone #:

Medication(s):

Prescribing Provider:

Date:

Purpose of Treatment

I understand that I have been prescribed injectable medication(s) as part of my treatment plan. I have elected to self-administer these medication(s) at home rather than receiving administration in the clinic.

Training and Instructions

I acknowledge that:

- I have received verbal and/or written instructions on proper storage, preparation, dosing, injection technique, and disposal of sharps.
- I have been given the opportunity to ask questions and feel comfortable performing the injections.
- I understand that failure to follow instructions may result in reduced effectiveness or adverse effects.

Risks and Possible Complications

I understand that self-administration of injectable medications may carry risks, including but not limited to:

- Injection-site reactions (pain, redness, swelling, bruising)
- Infection or improper injection technique
- Medication errors (incorrect dose or timing)
- Expected medication side effects specific to the prescribed medication
- Rare but serious adverse reactions

Responsibilities of the Patient

I agree to:

- Administer the medication exactly as prescribed

- Not adjust doses without medical authorization
- Store the medication properly
- Dispose of needles and syringes safely
- Notify Phi Clinic immediately of any adverse reactions, concerns, or errors
- Attend recommended follow-up visits and laboratory monitoring as advised

Emergency Situations

I understand that in the event of severe symptoms (e.g., allergic reaction, severe vomiting, difficulty breathing, chest pain), I should seek immediate emergency medical care and notify Phi Clinic as soon as possible.

No Guarantee

I understand that results are not guaranteed and may vary depending on individual response, adherence, and medical conditions.

Consent

I certify that I have read and understand this consent. All my questions have been answered. I voluntarily agree to self-administer my prescribed injectable medication at home.

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____