Tirzepatide Injection

CONSULTATION FORM

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

MEDICAL HISTORY

Please mark any of the following conditions you may currently have.

- ☐ Adrenal disorder
- ☐ Diabetes/retinopathy
- ☐ Kidney disorder/disease
- ☐ Angioedema
- ☐ Eating disorder history
- ☐ Liver disorder
- ☐ Anemia/blood disorder
- ☐ Epilepsy/seizures
- ☐ Mental health problems
- ☐ Depression/suicidal ideation
- ☐ Asthma
- ☐ Gastric/duodenum ulcer
- ☐ Neurological disorder
- ☐ Autoimmune condition
- ☐ Heart disease
- ☐ Pancreatitis
- ☐ Blood clotting disorder
- ☐ High blood pressure
- ☐ Parathyroid disorder
- ☐ Infective endocarditis
- ☐ Cancer/history of cancer
- ☐ High blood cholesterol
- ☐ Phlebitis
- ☐ Cholelithiasis
- ☐ HIV/AIDS or Hepatitis
- ☐ Renal failure
- ☐ Deep vein thrombosis
- ☐ IBD/IBS
- ☐ Substance abuse
- ☐ Thyroid disease

Currently, do you have any medical condition? ☐ No ☐ Yes _____

Any known allergies? ☐ No ☐ Yes _____

List any medications/ supplements you take regularly: _____

_____

Have you or a family member been diagnosed with either of the following?

☐ Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2) ☐ Medullary Thyroid Carcinoma

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

TIRZEPATIDE INJECTION CONSULTATION FORM

Are you allergic to any of the following?

GLP-1 Receptor Agonists Sodium Phosphate Adhesives/latex Benzyl Alcohol L-Carnitine

Any other known allergies? _____

Are you currently taking blood thinners (i.e., Aspirin/Warfarin), Bexarotene, Gatifloxacin, or any Diabetes medication (i.e. Insulin or sulfonylureas)? ☐ No ☐ Yes

If yes, please explain: _____

Have you had surgery in the past year? ☐ No ☐ Yes _____

HEALTH HABITS

Do you smoke? ☐ No ☐ Yes; please specify how many per day or week _____

_____

Do you drink alcohol on a regular basis? ☐ No ☐ Yes; please specify _____

How is your activity level? Sedentary Lightly active Moderately active Very active

What methods or interventions have you used to lose weight previously?

Diet Exercise Prescription medication Therapy Herbal supplements

What are your main motivations and concerns for wanting to lose weight with Semaglutide?

_____

_____

_____

What are your areas of concern?

Alcohol
Excess calories
Family history
Low energy
Medical condition
Pregnancy
Sedentary lifestyle
Sleep disruptions
Stress/busy lifestyle
Perimenopause
Hormonal changes
Other _____

FEMALE MEDICAL HISTORY - ONLY FEMALES

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Are you taking any contraceptives?: _____

I certify that all the information I have provided on this form is accurate and complete to the best of my knowledge. I am aware that withholding information or providing false details may lead to adverse reactions or complications.

_____ _____ _____

Client Name (Printed) Client (signature) Date

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

tirzepatide Injection

CLIENT CONSENT FORM

I consent to taking Tirzepatide injections as prescribed by my healthcare provider. Tirzepatide is a glucose-dependent insulinotropic polypeptide (GIP) receptor and GLP-1 receptor agonist for diabetes management, with off-label usage for chronic weight mTirzepatideInjection
anagement. I have been informed of the correct administering method and dosage. I will not take this medication if I have a history of the following:

- **You are pregnant or considering pregnancy while undergoing treatment with this medication.**
- **You or your family have a background of Medullary Thyroid Carcinoma (Thyroid Cancer) or Multiple Endocrine Neoplasia Syndrome Type 2 (MEN2).**
- **You have a medical history involving pancreatitis, kidney failure or disease, liver failure or disease, or gastrointestinal disorders.**
- **You are allergic to Semaglutide or other medications classified as GLP-1 agonists (such as Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®), or if you have undisclosed allergies.**
- **You have diabetes, retinopathy, or take blood sugar-lowering medication without consulting your endocrinologist**

Common side effects: nausea, diarrhea, decreased appetite, vomiting, constipation, abdominal pain, and indigestion.
Severe side effects: Contact your medical professional immediately if you experience the following:

- **Severe stomach pain or changes.**
- **Eye and vision changes, including blurry vision.**
- **Symptoms of hypoglycaemia (dizziness, headache, increased hunger, raised heart rate, sweating, anxiety, irritability, and confusion).**
- **Kidney problems, including decreased urination, swelling in the ankles or feet, shortness of breath, and increased tiredness.**
- **Gallbladder pain or changes, including symptoms of chalky stool, upper abdominal pain, nausea and vomiting, bloating and heartburn.**
- **Signs of a thyroid tumor, with a lump or swelling in the neck, trouble swallowing, voice hoarseness, or shortness of breath. Contact your doctor immediately.**

Stop the medication and seek immediate medical attention if you experience the following:

- **Pancreatitis, with severe upper abdominal pain that radiates to the back, which may be accompanied by vomiting.**
- **Serious allergic reaction, with rash, itching, swelling of the face, tongue, or throat and trouble breathing.**

<u>By signing below, you agree to the following:</u>

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any falsification of my medical history

Client Name (Printed)	Client (signature)	Date

Email: doctoriglesiasmiamilakes@gmail.com **Phone:305-381-5301** **Website: www.LysetteIglesiasMD.net**

tirzepatide Injection

CLIENT CONSENT FORM

Possible drug interactions: anti-diabetic agents (i.e., Insulin and Sulfonylureas) can lead to an increased risk of hypoglycemia (low blood sugar). Gatifloxacin also increases the risk of hypoglycaemia. Inform your provider of any medications that may lower blood sugar. Do not combine with other GLP-1 agonist medicines (i.e., Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®). Bexarotene increases the risk of pancreatitis and should not be taken alongside Tirzepatide.

Warnings: Tirzepatide may cause serious side effects: pancreatitis, hypoglycaemia (low blood sugar), kidney problems, severe stomach pain and problems, changes in vision, gallbladder pain and issues, as well as allergic reactions.
If you take birth control pills, they may not work as effectively while taking Tirzepatide. Discuss this with your healthcare provider to discuss the most appropriate options.

I acknowledge that Tirzepatide is one part of a comprehensive lifestyle approach that includes a healthy diet and exercise, and regular follow-up visits to adjust dosages are necessary.

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any falsification of my medical history

Client Name (Printed)	Client (signature)	Date

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

Tirzepatide Injection

CANCELLATION POLICY

In order to ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a $25.00 deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 24 hours prior to your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 24 hours' notice, a $25.00 cancellation fee will be charged.

Please note that if you arrive more than 15 minutes late for your appointment, it will be considered a no-show and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Client Name (Printed)	Client (signature)	Date

To contact us use our Email mentioned below, do not leave a message on the answering machine because it will not be heard due to the volume of calls.

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

Tirzepatide Injection

PHOTO & VIDEO RELEASE FORM

I, _____ hereby grant and authorize _____Lysette Iglesias MD_____ I grant the right to capture, modify, edit, reproduce, exhibit, publish, distribute, and utilize any photographs, videos, and/or audio recordings taken of me for lawful promotional purposes. These materials may include, but are not limited to, newspapers, flyers, posters, brochures, advertisements, press kits, websites, social media platforms, and other forms of print and digital communication. I provide this authorization without expecting any payment or other forms of consideration.

This authorization remains in effect indefinitely and applies to all languages, media, formats, and markets, whether currently known or discovered in the future.

I willingly waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and accept that the materials created through this agreement will be the property of the _____Lysette Iglesias MD_____ and will not be returned to me.

I hereby release and discharge the _____Lysette Iglesias MD_____ from any liability, claims, or legal actions that may arise, including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.

By signing below, I confirm that I have thoroughly read and comprehended the entirety of the release agreement stated above.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement

Client Name (Printed)	Client (signature)	Date

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

tirzepatide Injection

CARE ADVICE

Your body will have optimal results when you maintain a regimen to support your health and well-being.

- **Storage: Store the injections in the refrigerator and do not freeze. Throw away used needles in a hard, closed container, and keep this container away from children and pets.**
- **Eating Habits for nausea: Eat slowly and in smaller portions, drink clear liquids, and avoid lying down right after eating. Focus on foods that contain more water and maintain a regular meal schedule while limiting snacking between meals.**
- **Fibrous Diet: Emphasize a fibrous diet, including fruits and vegetables high in fiber.**
- **Small, High-Protein Meals: Opt for small, high-protein meals, as digestion is slowed down while on this medication.**
- **Low-Fat Foods: Avoid foods high in fat as they may contribute to nausea and vomiting. It's recommended to take injections before meals, rather than after, to minimize potential side effects from eating high-fat or high-sugar foods.**
- **Limit Alcohol Intake: Avoid alcohol consumption while taking Tirzepatide injections, as it can increase the risk of hypoglycemia, dehydration, nausea, and vomiting.**
- **Caffeine: Be cautious with caffeine consumption, as it may affect the action of Tirzepatide, leading to low blood sugar levels or dehydration.**

Client Name (Printed)	Client (signature)	Date

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

tirzepatide Injection

FREQUENTLY ASKED QUESTIONS

WHAT IS TIRZEPATIDE AND HOW CAN IT HELP WEIGHT LOSS?

Tirzepatide is a GIP and GLP-1 receptor agonist, and when administered as an injection, it helps regulate appetite and food intake. The medication can assist adults with obesity or those who are overweight in their weight management journey.

HOW DO I TAKE TIRZEPATIDE INJECTIONS?

Tirzepatide is usually injected once a week. It comes in a pre-filled pen, and you can administer the injection under the skin of your stomach, thigh, or upper arm. Your healthcare provider will guide you on the proper technique.

HOW LONG DOES IT TAKE FOR TIRZEPATIDE TO WORK?

Tirzepatide may start to show noticeable effects on weight loss within a few weeks of regular use. However, individual responses may vary. It's essential to stay committed to healthy eating habits and physical activity, to achieve the best and sustainable weight loss results.

DOES TIRZEPATIDE REALLY WORK?

Tirzepatide is not a universal solution for everyone, but during clinical studies, those on the medication on average experienced between 5%-15% loss of body weight. For the best results, this treatment is most effective with healthy lifestyle changes.

WILL MY INSURANCE COVER TIRZEPATIDE?

Insurance companies may provide coverage for Tirzepatide when it is prescribed for the treatment of type 2 diabetes. However, coverage for Tirzepatide as a weight loss medication is not typical. However, it's always best to check with your insurance provider.

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

tirzepatide Injection

CLIENT TREATMENT RECORD

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

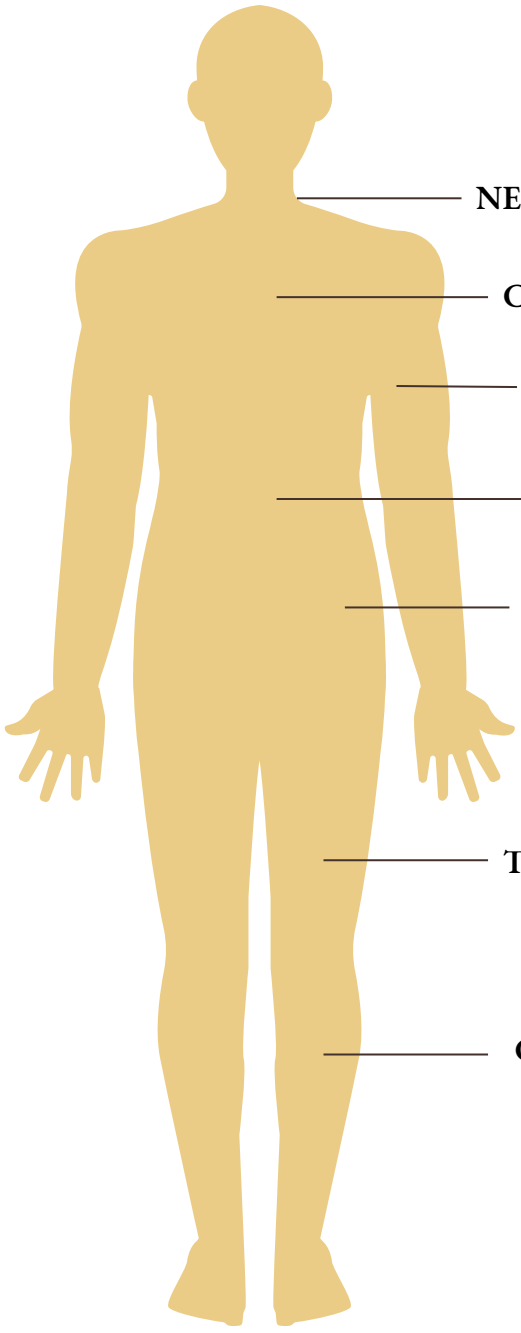
Phone: _____ Email: _____

DATE	MEDICATION	FREQUENCY	DOSE	NOTES

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

tirzepatide Injection

CLIENT RECORDS MEASUREMENTS

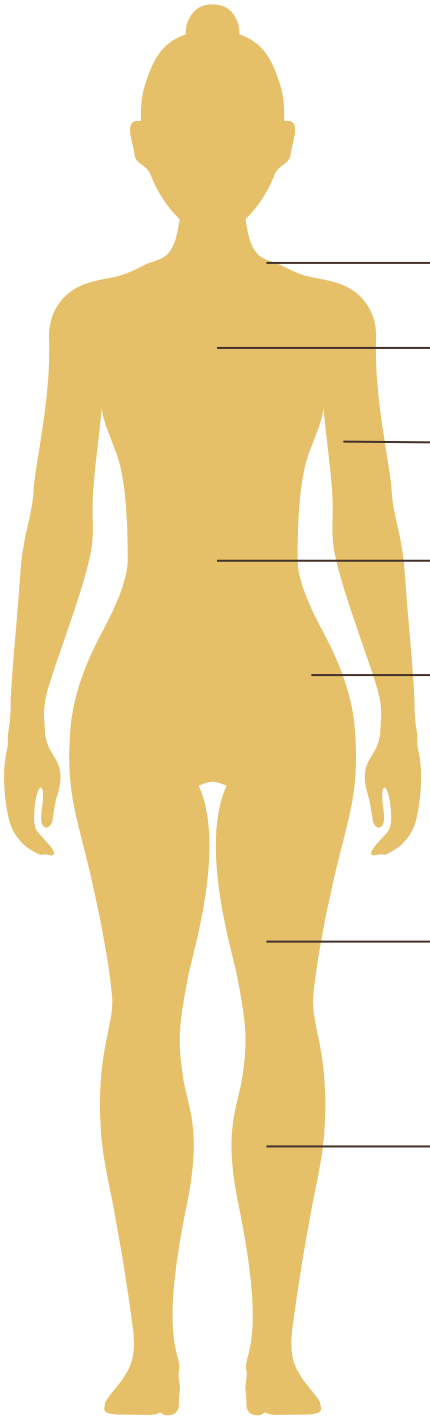


	BEFORE DATE	AFTER DATE
NECK		
CHEST		
ARM		
NAVEL		
HIP		
THIGH		
CALF		

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

tirzepatide Injection

CLIENT RECORDS MEASUREMENTS



	BEFORE DATE	AFTER DATE
NECK		
CHEST		
ARM		
NAVEL		
HIP		
THIGH		
ULNA		

Email: doctoriglesiasmiamilakes@gmail.com Phone:305-381-5301 Website: www.LysetteIglesiasMD.net

tripeptide injection

BODY COMPOSITION

CUSTOMER INFORMATION:

Name: _____ Date: _____

Birthdate: _____ Age: _____ ☐ Female ☐ Masculine ☐ Nonbinary

HAVE YOU BEEN FASTING FOR AT LEAST THE LAST 2 HOURS?	Yes ☐	No ☐
HAVE YOU DONE ANY PREVIOUS EXERCISES?	Yes ☐	No ☐
ARE YOU GOING THROUGH YOUR MESTRUAL PERIOD?	Yes ☐	No ☐
HAVE YOU CONSUMED ANY ALCOHOLIC DRINKS Yes No	Yes ☐	No ☐
IN THE LAST 24 HOURS?	Yes ☐	No ☐
DO YOU HAVE A PACEMAKER?	Yes ☐	No ☐
DO YOU HAVE ANY METAL OBJECTS? Axle chains, handles, esct rings	Yes ☐	No ☐
ARE YOU PREGNANT?	Yes ☐	No ☐

_____ _____ _____

Customer name (printed) Client's signature) Date

Email: doctoriglesiasmiamilakes@gmail.com Telephone: 305-381-5301 Website: www.LysetteIglesiasMD.net

Invoice

BILLED TO:
Clients Name
Address:
Phone:
Email: hello@reallygreatsite.com

INVOICE NO: #
Issue Date:
Issue Due:

NO	DESCRIPTION	PRICE	QTY	TOTAL
1	Item			
2	Item			
3	Item			
4	Item			
5	Item			

TOTAL

YOUR COMPANY NAME
Address:

City/ State/ Zip Code

Phone:

Email:

Subtotal
Discount (10%)
Total
Tax (10%)
Amount due

PAYMENT INFORMATION
Bank: YourBank Name
Account Name:
Account/Roitng No.:
PayPal:

Thank You

LYSETTE IGLESIASMD
doctoriglesiasmiamilakes@gmail.com // (305)381-5301