SEMAGLUTIDE CONSENT:

I understand that **SEMAGLUTIDE** may involve risk. I understand that there are no refunds, returns, or store credit for medication. There is no weight loss guarantee. I have read and understand the information given to me about the medication. I have asked and answered any questions that I may have after reading this form. I understand the possible side effects are nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distention, eructation, hypoglycemia in patients with type 2 diabetes, flatulence, gastroenteritis, gastroesophageal reflux disease, and nasopharyngitis. These side effects are usually mild and decrease over time as your body becomes adjusted to the medication. If symptoms are severe or are worsening, please contact your healthcare provider immediately as this might be a sign of pancreatitis or gallbladder disease. I understand that I may quit the injections at any time. I agree to stop the **SEMAGLUTIDE** if I become pregnant and agree to advise our office should I decide to become pregnant. If an illness does occur, I understand that I need to contact Dr. White immediately and that Dr. White is not serving as your primary care physician during this program.

Semaglutide is contraindicated in patients with a personal or family history of MTC or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).

My Primary Care Physician is _____.

If I experience an emergency, I understand that I need to go to an emergency facility.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION ABOVE, HAVE HAD YOUR QUESTIONS ANSWERED, HAVE HAD POTENTIAL SIDE EFFECTS EXPLAINED, AND AGREE TO NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR HEALTH STATUS OR MEDICATIONS PRESCRIBED.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE WORK NECESSARY TO ACHIEVE SUCCESS ON THIS MEDICATION.

_____ _____

Patient's Name (PLEASE PRINT) Patient's Signature

_____

Date

_____

Witness