SEMAGLUTIDE CONSENT FORM

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This document is intended to serve as a confirmation of informed consent for compounded semaglutide, which is a prescription weight management medication.

A. Patient Informed Consent

1. I voluntarily request that Genise Binns, PMHNP-BC (provider) treats my medical condition.
2. I have informed my provider of any known allergies, my medical conditions, medications, social/family history.
3. I have the right to be informed of any alternative options, side effects, and the risks and benefits.
4. I understand the mechanism of action of the medication.
5. I understand how it is to be administered.
6. I understand the prescription will come from a compounding pharmacy, which is not FDA approved. I have been told that the manufacturing facility itself is FDA monitored along with third party testing on the medication itself.
7. Prices may vary and change. My charge will include my time with Provider Binns (in person and via communication outside of the office), supplies, and medication.
8. Provider Binns may change the pharmacy based on several factors (availability, shipping time, cost). Provider Binns will tell you as this happens.
9. It has been explained to me that this medication could be harmful if taken inappropriately or without advice from the provider.
10. I understand this medication may cause adverse side effects (see below). I understand this list is not complete and it describes the most common side effects, and that death is also a possibility of taking this medication. I understand symptoms may be worse after there has been a change in my medication dose or when first starting the medication.

Common side effects include, but are not limited to:

- Gastrointestinal: Nausea/vomiting, abdominal pain, Diarrhea/constipation, dyspepsia, abdominal distension, eructation, flatulence, gastroenteritis, GERD, gastritis, lipase increase, amylase increase.
- Neurological: Headache, dizziness
- Cardiac: Heart rate increase, Hypotension
- Endocrine: Fatigue, hypoglycemia (diabetic patients), alopecia
- Ophthalmic: Retinal disorder (diabetic patients)
- Skin: redness or pain at injection site

Serious Reactions include, but are not limited to:

- Thyroid C-cell tumor (animal studies)
- Medullary thyroid cancer
- Hypersensitivity reaction
- Anaphylaxis
- Angioedema
- Acute kidney injury
- Chronic renal failure exacerbation
- Pancreatitis
- Cholelithiasis
- Cholecystitis
- Syncope

B. I understand that I have the following responsibilities

1. I agree to obtain prescriptions for compounded semaglutide only from Genise Binns, PMHNP-BC.
   a. If I am looking to transition to a non-compounding pharmacy or seek insurance coverage, I will tell Provider Binns in advance.

2. Medical history: I will tell Provider Binns my complete medical history, including: allergies, medications, medical / surgical / social/family history.
   a. Genise Binns, PMHNP-BC may ask to review, with your permission, your medical history (medications, recent lab results, pertinent imaging results).
   b. I understand that if I become pregnant or start trying for pregnancy, I must stop this medication.
   c. I will be honest to the best of my ability the history she needs to know.
   d. I will tell my provider any updated health information (medication, allergies, personal medical issues/surgeries/social history, or family history changes).
   e. My provider can discuss my treatment plan with any co-treating pharmacist and/or healthcare provider.
   f. I will always tell other providers about all medications I am taking.
   g. Provider Binns may ask for me to seek additional labs while on treatment to ensure it's safety.

3. Directions for use: I will take my medications only as prescribed according to the directions, led by Genise Binns, PMHNP-BC.
   a. If I feel my medications are not effective, or are causing undesirable side effects, I will contact my provider for instructions.
   b. I will not adjust my medications without prior instruction to do so.
   c. I understand that the medication must be either kept frozen or refrigerated.
   d. I understand this medication must be self-injected in the subcutaneous tissue once weekly. I will not inject any less than 7 days unless directed by Genise Binns, PMHNP-BC (example: travel).
   e. I will not share needles and dispose of needles safely.
   f. If I'm having troubles with the administration of the medication, I will seek help from Provider Binns.
   g. The medication expires after 12 weeks. I will refer to the Beyond Usage Date (BUD).

4. Refills:
   a. All refills will require an appointment.
   b. I understand, I may need to schedule refill appointments ahead of time to avoid delays in refills.
   c. I understand that I will be informed when refill is ordered and available.
   d. I will not ask for early refills.
   e. I understand that I may be asked to bring the medication with me to my appointments to check the quantity left or asses how I am injecting.

5. Safety:
   a. I understand it is important to keep my medication away from children (<18 years old)
   b. I am the only one who will use my medication. I will not give or sell my medication to anyone else.

6. If Genise Binns, PMHNP-BC deems it appropriate to start weaning my medication or transition to maintenance dosing, I will comply.

C. Discontinuation of medication: I understand that Provider Binns may stop prescribing my medications if:

a. I am having unfavorable side effects or it's not working to treat my medical condition
b. I have been untruthful in my medical or family history
c. I do not follow through with the recommended plan of care set by Provider Binns.
d. I do not follow any parts of "Part B: responsibilities" in this agreement.

I have read this form in its entirety. It has been explained to me. I have had the opportunity to ask questions and have all my questions answered. I fully understand the above information and have no further questions. By signing this form, I voluntarily give my consent for treatment and agree to the risks.

_____ _____

Signature Date

SEMAGLUTIDE FORM
CLIENT INTAKE

Center for Seeking Peace
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PHONE: 757-704-4747
WEB: centerforseekingpeace.com

MEDICAL HISTORY

CLIENTS NAME

ADDRESS ZIP CODE

PHONE EMAIL AGE D.O.B

GENDER □ F □ M OCCUPATION

DRIVER'S LICENSE # STATE ISSUED EXP

EMERGENCY CONTACT

NAME PHONE

ADDRESS

I AM □ MARRIED □ NOT MARRIED □ DIVORCED □ WIDOWED □ OTHER

PCP INFORMATION

NAME PHONE

ADDRESS

_____ _____

PATIENT SIGNATURE DATE

What is your purpose for having Semaglutide treatment?

What is the reason you want to lose weight?

How long has your weight been a problem?

Are you currently at your heaviest weight (if no, how much did you weight at your heaviest weight)?

My worst food habit is

Are you a stress eater? Do you eat in the middle of the night?

Does your significant other struggle with weight issues?

What methods have you previously tried to lose weight?

Are you scared of needles/needle phobic/faint easily when you have blood taken?

WOMEN ONLY ANSWER THE FOLLOWING:

Check those questions to which you answer yes (leave the others blank).

□ Are you trying for pregnancy or planning pregnancy in the near future?

□ Are you or could you be pregnant? Are you breastfeeding?

□ Are you on any type of hormone replacement therapy?

□ Are you on any contraceptive methods?

Number of live births Comments

_____ _____

PATIENT SIGNATURE DATE

MEN AND WOMEN ANSWER THE FOLLOWING:

List any prescription medications you are now taking

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:

Date of last complete physical examination: □ Normal □ Abnormal □ Never □ Can't remember

List any other medical or diagnostic test you have had in the past two years:

List hospitalizations, including dates of and reasons for hospitalization (including any surgeries):

List any drug, food or environmental allergies you may have:

Are you on any blood thinners?

Weekly alcohol intake?

Do you or have you ever smoked?

At this time, my current exercise routine includes

PAST OR CURRENT MEDICAL HISTORY

Check those questions to which you answer yes (leave the others blank

- □ Heart disease (such as heart attack, rheumatic fever, irregular heartbeat, angina, heart murmur, chest pain)
- □ Diseases of the arteries
- □ High blood cholesterol
- □ Anemia or other blood disorders i.e. Sickle Cell disease, Thalassemia
- □ History of dizziness, seizures or stroke
- □ Medullary thyroid cancer
- □ Any thyroid disease/problems
- □ Parathyroid problems or Adrenal gland problems
- □ Diabetes or abnormal blood-sugar tests
- □ Phlebitis (inflammation of a vein)
- □ Deep vein thrombosis/blood clot in the leg (DVT) or PE (pulmonary embolism)
- □ Gallstones or any gallbladder disease (including jaundice)
- □ High blood pressure
- □ (Hypertension) Severe reflux
- □ Any breathing problems (such as asthma, COPD, bronchitis)
- □ Infective endocarditis
- □ Kidney problems including
- □ Chronic Kidney disease (CKD)
- □ Pancreas/digestion problems (including acute or chronic pancreatitis)
- □ Stomach/duodenum/gastric ulcer
- □ Liver problems (including hepatitis, liver failure, fatty liver, alcoholic liver disease)
- □ Any neurological problems (including Parkinson Disease)
- □ Severe stomach/gut problems (incl. inflammatory bowel disease: Crohn's disease or Ulcerative colitis)
- □ Irritable bowel syndrome (IBS)
- □ Jaundice or gall bladder problems
- □ Skin conditions Eating disorder (such as anorexia or bulimia)
- □ Mental health problems (including personality disorder, psychosis, diagnosis of depression)
- □ Self-diagnosis of depression, low mood, nervous or emotional problems
- □ Substance abuse (including alcohol or drugs)
- □ Any allergies (including food or drugs)
- □ Do any of the discussed contraindications apply to you (refer to last page)

_____

Patient Signature

FAMILY HISTORY

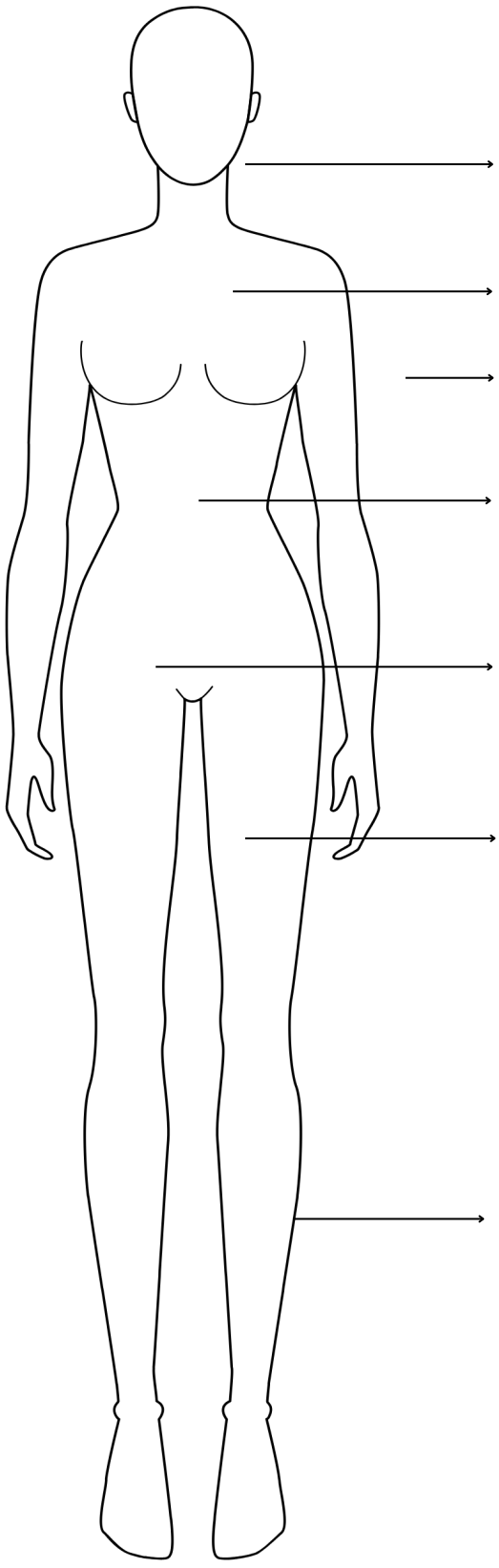
Check those questions to which you answer yes (leave the others blank

- □ Heart attacks under age 50
- □ Strokes under age 50
- □ High blood pressure
- □ Elevated cholesterol
- □ Diabetes
- □ Asthma or hay fever
- □ Skin allergies
- □ Congenital heart disease (existing at birth but not hereditary)
- □ Heart operations
- □ Red blood cell disorders i.e. Sickle Cell, Thalassemia, and Anemia
- □ Glaucoma
- □ Kidney Disease
- □ Obesity (20 or more pounds overweight)
- □ Leukemia or cancer under age 60

_____
Patient Signature

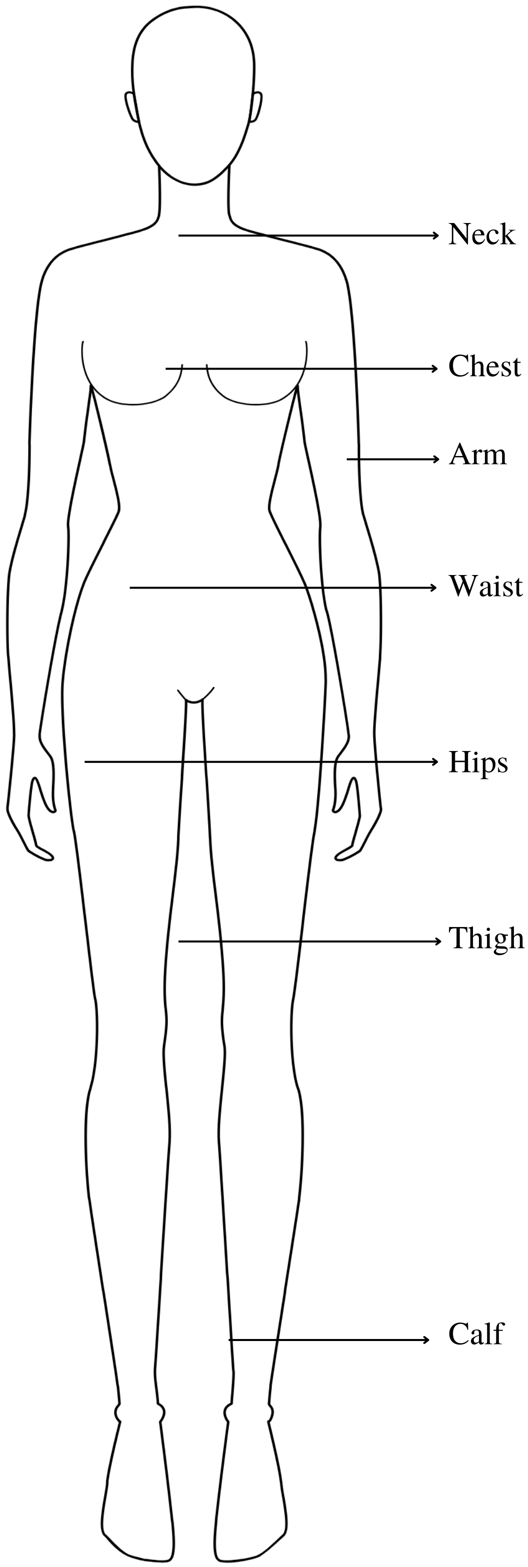
_____ _____ _____
Practitioner Name Signature Date

BODY MEASUREMENT TRACKER



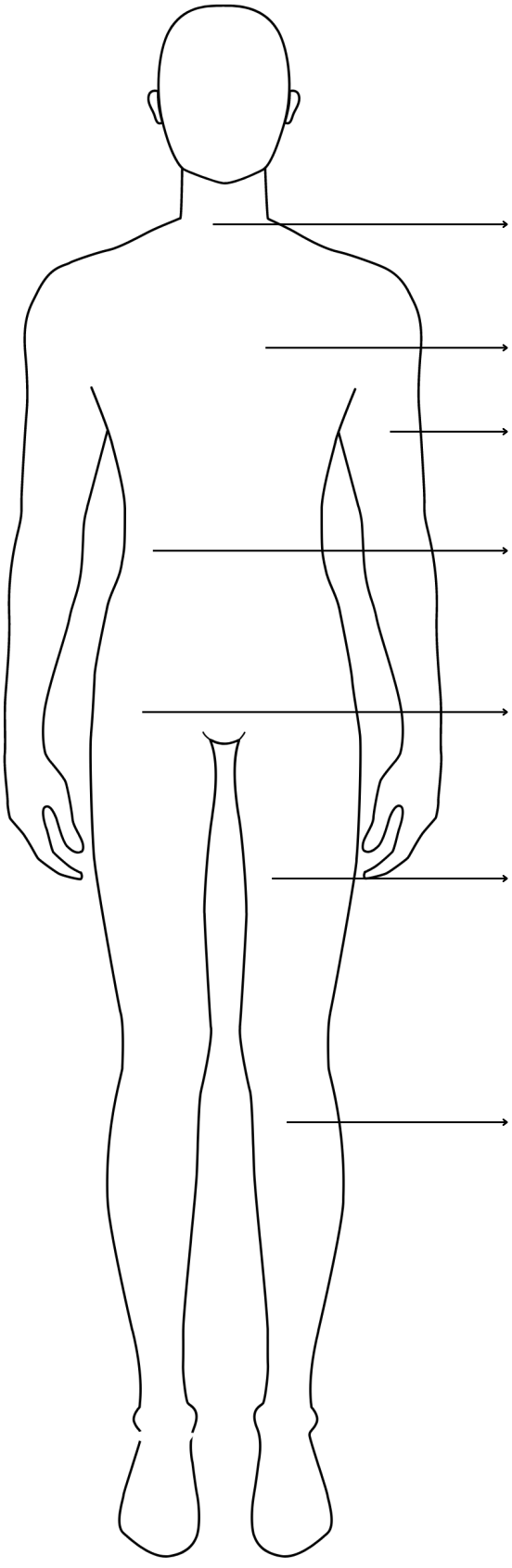
	BEFORE		AFTER	
	Date:		Date:	
Neck				
Chest				
Arm	L	R	L	R
Waist				
Hips				
Thigh	L	R	L	R
Calf	L	R	L	R
Weight				

BODY MEASUREMENT TRACKER



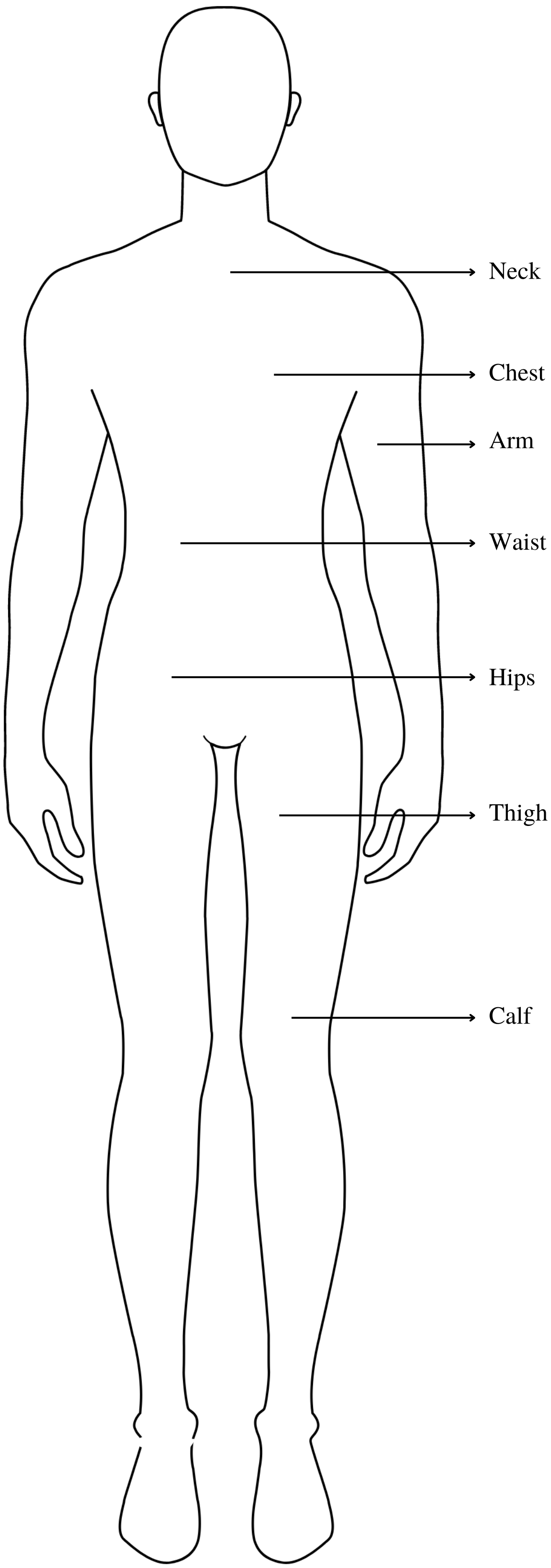
Date	Neck	Chest	Arms	Waist	Hips	Thighs	Calves

BODY MEASUREMENT TRACKER



	BEFORE		AFTER	
	Date:		Date:	
Neck				
Chest				
Arm	L	R	L	R
Waist				
Hips				
Thigh	L	R	L	R
Calf	L	R	L	R
Weight				

BODY MEASUREMENT TRACKER



Date	Neck	Chest	Arms	Waist	Hips	Thighs	Calves