Semaglutide Assisted Weight-Loss Program
Consent for Treatment

Today's Date: _____

Name: _____

DOB: _____/_____/_____

By my signature below I do willingly request and consent to a prescription of Semaglutide by Glow Health Medical Clinic. . While proven successful in weight loss, I understand that there is no warrant or guarantee of results from using Semaglutide weekly injections.

1. I understand that as part of this program I will be required to complete a Medical History and meet with a Medical Provider to determine my candidacy. I understand that initial blood tests may be required in order to rule out any conditions that would disqualify me from the program or require any prior treatment before starting the program. I agree to immediately report any problems that might occur to Glow Health Medical Clinic, as well as my Primary Physician during the treatment program.

2. I understand that there could be risks involved, as there are with all medications. Failure to comply with the dosage recommendation and dietary restrictions could alter the weight loss results.

3. I agree that I am, and will be, under the care of my primary medical provider for all other medical conditions.

4. I understand that treatments for weight loss are rarely covered by insurance companies. We do not accept or bill insurance for this program. We can provide a superbill in which you can submit to your insurance company for possible reimbursement of the office visit fee. .

5. I understand that medication is ordered on a per patient basis and is sent to the pharmacy for the full month(s) of injections. Patients can use insurance to help cover the cost of medication if available. *At any point I can choose to discontinue the program, however program fees paid to Glow Health Medical Clinic are non-refundable. .*

6. I acknowledge that all statements provided on the Medical History Forms are true and accurate to the best of my knowledge and that my treatments will be based on the information provided herein and if I willingly withhold information, I accept full liability for any consequence that may arise therefrom.

7. I acknowledge that Semaglutide is in high demand throughout the country and despite writing the prescription, it is possible that the medication may not be available.

8. **SEMAGLUTIDE CONTRAINDICATIONS**: I UNDERSTAND THAT IF I HAVE ANY OF THE FOLLOWING I SHOULD NOT TAKE SEMAGLUTIDE INJECTIONS:
Personal or family history of medullary thyroid carcinoma or in patients with Multiple Endocrine Neoplasia syndrome type 2 (4, 5.1). •Known hypersensitivity to semaglutide, Diabetic retinopathy (a type of damage to the eye from diabetes), low blood sugar, decreased kidney function, pancreatitis, and/or kidney disease with likely reduction in kidney function.

WARNINGS AND PRECAUTIONS ——— •***Thyroid C-cell Tumors***: In rodents, semaglutide causes dose-dependent and treatment duration-dependent thyroid C-cell tumors at clinically relevant exposures. It is unknown whether Semaglutide causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), *in humans as human relevance of semaglutide-induced rodent thyroid C-cell tumors has not been determined* •
Acute Pancreatitis: Has occurred in clinical trials. Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed (5.2). •
Acute Gallbladder Disease: Has occurred in clinical trials. If cholelithiasis is suspected, gallbladder studies and clinical follow-up are indicated (5.3).
•***Hypoglycemia****:* Concomitant use with an insulin secretagogue or insulin may increase the risk of hypoglycemia, including severe hypoglycemia. Reducing the dose of insulin secretagogue or insulin may be necessary. Inform all patients of the risk of hypoglycemia and educate them on the signs and symptoms of hypoglycemia (5.4, 7.1).
Acute Kidney Injury: Has occurred. Monitor renal function when initiating or escalating doses of Semaglutide in patients reporting severe adverse gastrointestinal reactions or in those with renal impairment reporting severe adverse gastrointestinal reactions (5.5).
•***Hypersensitivity Reactions****: Anaphylactic* reactions and angioedema have been reported postmarketing. Discontinue Semaglutide if suspected and promptly seek medical advice (5.6).
•***Diabetic Retinopathy*** Complications in Patients with Type 2 Diabetes: Has been reported in trials with semaglutide. Patients with a history of diabetic retinopathy should be monitored (5.7).
•***Heart Rate Increase***: Monitor heart rate at regular intervals (5.8). •
Suicidal Behavior *and Ideation*: Monitor for depression or suicidal thoughts. Discontinue Semaglutide if symptoms develop (5.9).

9. I have read and understand all the above statements and conditions and have been informed of potential side effects.

Patient Signature:_____Date:_____