

**WEIGHT LOSS PROGRAM CONSENT FORM**

 I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize my Looking Good Cosmetic Surgery physician(s), or advanced practice clinician (s) and/or whomever may be designated as the medical assistant(s), to help me in my weight reduction efforts.I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavioral modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low caloric diet, or a protein supplemented diet. I further understand that if appetite suppressants are prescribed, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me to my complete satisfaction that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the medication product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks associated with remaining overweight are tendencies to have high and increasing higher blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances made to me that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require drastic changes in eating habits and permanent changes in behavior to be treated successfully.

*I understand that failing to show up for an appointment I have scheduled, without calling or contacting* *Looking Good Cosmetic Surgery ahead of time, represents a disruption to operation of the clinic. Failure to show up (“No-Show”) for a pre*‐*appointed Follow Up Visit, or failure to cancel* ***at least one full business day*** *prior to a scheduled visit will result in need to pay for the missed visit and pre-pay the next Medical Weight Loss Visit.*

I have read and fully understand this consent form and “no show” policy. I have had all of my questions answered to my complete satisfaction. I have been given all the time that I need to carefully read and understand this form.

\_\_\_\_\_\_\_\_ **(Initials) By my initials, I acknowledge that I have had an opportunity to review Looking Good Cosmetic Surgery’s HIPPA Policy and also acknowledge that I should request a copy, a copy will be provided to me.**

Signed,

 Patient Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Or person and relationship with authority to consent for the patient)

**Looking Good Cosmetic Surgery**

177 North Dean St

Englewood, NJ 07631

(201) 408-5178

**POLICIES**

**Communication is key in providing superior care and achieving optimal results. We will do our utmost to communicate clearly and meet your expectations. In turn you will also be expected to communicate clearly with us. Please inform us if you must**

**miss an appointment or change the care plan in some way. In order for us to provide optimal access to care and achieve the best outcomes for you, the following policies apply to the Looking Good Cosmetic Surgery Weight Loss program:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_(Initial Here)  | 1. The Initial Medical Weight Loss Consult is a long appointment—in order to set aside this amount of time for a single patient, it **MUST BE PRE**‐**PAID**  |
|  \_\_\_\_\_\_ (Initial Here)  | 2. Patients should call the clinic if an appointment must be cancelled or rescheduled **at least 1 full business day** prior to scheduled appointment.   |
|  \_\_\_\_\_\_(Initial Here)  | 3. If 60 or more days pass since the last medical weight loss visit, without prior arrangement between staff and patient, the patient will be considered to have dropped out of the program. 1. Grace Period: If patient has not been seen in a month or two, but has not “no‐showed” and less than 60 days have passed, the patient may resume progress appointments without “restart” fees

  |
|  \_\_\_\_\_\_ (Initial Here)  | 4. If **more than 180 days** have passed since last visit, a patient who wishes to “Re‐start” in the weight loss program will be scheduled in the usual fashion for an Initial Weight Loss Welcome Visit.  |
|    \_\_\_\_\_\_ (Initial Here)  | 5. No weight loss medications will be prescribed for any patient outside the context of the Looking Good Cosmetic Surgery Medical Weight Loss Program, nor outside the setting of the usual office visit. Weight loss medications are prescribed in similar fashion to any other medication that physicians prescribe. If it is determined to not be helpful in achieving results, or is detrimental to the patient, the physician has sole discretion regarding its continued use.  |

**I have read the above policies and agree to be held accountable to these terms.**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(Signature) (Date)**

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Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

**Describing My Current Climate**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **At this time, my exercise routine includes…**  | Activity:  | Minutes:  |  | Times/ week:  |
| **My Current Stress level is…**  | None  | Low  |  | Medium  | High  |
| **My biggest stressor is…**  | Job  | Relationship  |  | Health  | Other:  |
| **My tobacco use is…**  | Current  | Former  |  | Never  | Quitting  |
| **My current alcohol use is...**  | None  | Occasional  | Weekly  | Daily  | A Problem  |
| **My current recreational substance use is…**  | None  | Type:  |  | Frequency:  |
| **My current TV/computer time per week is…**  | Less than 7hrs  | 7 to 15 hrs.  |  | Over 15 hrs.  |
| **I have had a problem with** **drug or alcohol addiction in past…**  | No  | Yes  | Which?  |  |

My **Most Important Reasons** for wanting to *Change My Health Climate* are:

|  |  |
| --- | --- |
|   |   |

 I decided to come to Looking Good Cosmetic Surgery Medical Weight Loss to help me with my weight because:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My weight at age 20 was \_\_\_\_\_\_\_\_\_\_ lb.

My Weight one year ago was:\_\_\_\_\_\_\_\_\_ lb.

The MOST I ever weighed (non-pregnant) was\_\_\_\_\_\_\_\_ lb.

I began to gain weight because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My **worst** food habit is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I am a **stress** eater Yes No

 I eat in the middle of the night Yes No

During the last 3 months, I have had episodes of excessive overeating where I ate more than what most people would

|  |  |  |
| --- | --- | --- |
| eat in a similar period of time:  *If “No” go to* ***Beverage*** *box below*  *If “Yes” complete the following:*  | Yes  | No  |
| During these episodes I feel I have NO CONTROL over my eating  | Yes  | No  |
| I eat during these episodes even when I am not hungry  | Yes  | No  |
| During these episodes I feel embarrassed by how much I ate  | Yes  | No  |
| During these episodes I feel disgusted with myself, or guilty afterward In the past 3 months, I have sometimes made myself vomit to try to  | Yes  | No  |
|  control my weight  | Yes  | No  |

 **BEVERAGE:** I **drink** the following routinely (circle all that apply):

|  |  |
| --- | --- |
| **Beverage**  | **Number per Week**  |
| High in Sugar  |   |
| Sports/Energy Drinks  |   |
| Carbonated Drinks  |   |

**Typical Meals** for me include: (if “none”, please note that)

|  |  |  |  |
| --- | --- | --- | --- |
| **Breakfast**  | **Lunch**  | **Supper**  | **Snacks**  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

I have done the following **weight loss programs** before:

|  |  |  |
| --- | --- | --- |
| **Program**  | **Year**  | **Result**  |
|   |   |   |
|   |   |   |
|   |   |   |

I have used weight loss medication before: No Yes If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am currently using weight loss products: No Yes If yes, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The person(s) closest to me support my intentions to do this program: No Yes Unsure

Long term, I would like to maintain my weight at \_\_\_\_\_\_\_\_lbs. (This is my “New Climate” weight)

I would like to be at my “New Climate” weight in \_\_\_\_\_\_\_ months

**If you would like to be added to our private Looking Good Cosmetic Surgery Medical Weight Loss Facebook site for additional recipes and support, please provide the e-mail address that is associated with your Facebook account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

My regular doctor is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Communication in healthcare is important in order for you to receive the most comprehensive care possible.

**Would you like us to communicate with your regular doctor about your care here at Looking Good Cosmetic Surgery Y / N**

 At this time my overall health is (circle): Excellent Good Fair Poor

 Previous or Current Health **Conditions I have had** include: (check all that apply to you)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|   | High Blood Pressure  |   | Depression  |   | Sleep Apnea  |   | Thyroid Problems  |
|   | Diabetes  |   | Anxiety  |   | Asthma  |   | Gout  |
|   | Heart Disease  |   | PTSD  |   | COPD  |   | Arthritis  |
|   | Kidney Disease  |   | Binge Eating Disorder  |   | Acid Reflux  |   | Fibromyalgia  |
|   | Chronic Leg Swelling  |   | Anorexia Nervosa  |   | Irritable Bowel/Colitis  |   | Osteoporosis  |
|   | Bleeding Disorder  |   | Bulimia  |   | Fatty Liver  |   | Urinary Incontinence  |
|   | Blood Clot  |   | ADHD/ADD  |   | Crohn’s Disease  |   | Polycystic Ovaries  |
|   | Anemia  |   | Bipolar Illness  |   | Ulcerative Colitis  |   | Menopause  |
|   | Cancer  |   | Alcohol/Drug abuse  |   | Liver/Gallbladder disease  |   | Other  |
|   | Eczema  |   | Headache/Migraine  |   | Stomach Ulcers  |   |   |

 **Surgeries** I have EVER had include:

|  |  |  |  |
| --- | --- | --- | --- |
| **Type**  | **Date**  | **Type**  | **Date**  |
| **1.**  |  | **4.**  |  |
| **2.**  |  | **5.**  |  |
| **3.**  |  | **6.**  |  |

 **Hospitalizations, and/or Serious Injuries** I have EVER had include:

|  |  |  |
| --- | --- | --- |
| Reason  | Hospital Name  | Date  |
| **1.**  |   |   |
| **2.**  |   |   |
| **3.**  |   |   |

I am **allergic** to, or do not tolerate the following medicines:

|  |  |
| --- | --- |
| **None (circle if appropriate)**  | **2.**  |
| **1.**  | **3.**  |

***Prescription* Medications** I CURRENTLY take are:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name  | Dose and Frequency  | Medication Name  | Dose and Frequency  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

***Over The Counter*** **Medications and/or Supplements/Vitamins** I CURRENTLY take are:

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name  | Dose and Frequency  | Medication Name  | Dose and Frequency  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

My **Family’s Health** History (circle brother or sister as appropriate; check all that apply)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  **Disease**  | **Father** Age: Living: Y N  | **Mother** Age: Living: Y N  | **Brother/Sister** Age: Living: Y N  | **Brother/Sister** Age: Living: Y N  | **Brother/Sister** Age: Living: Y N  | **Brother/Sister** Age: Living: Y N  |
| Heart Attack/Stroke  |   |   |   |   |   |   |
| Diabetes  |   |   |   |   |   |   |
| Cancer  |   |   |   |   |   |   |
| Psychiatric  |   |   |   |   |   |   |
| Obesity  |   |   |   |   |   |   |
| Other  |   |   |   |   |   |   |

Symptoms I am **experiencing at this time**: (check all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | Unexpected Weight Loss/Gain  |   | Ulcers/Wounds on feet  |   | Sadness/Depression  |
|   | Swollen Glands  |   | Calf or leg pain while walking  |   | Anxiety/Nervousness  |
|   | Feeling Sick  |   | Change in bowel habits  |   | New/unusual headaches  |
|   | Longstanding pain  |   | Heartburn  |   | Falling down  |
|   | Fever/Chills/Sweats  |   | Abdominal Pain  |   | Skin rashes  |
|   | Disturbance in Vision  |   | Painful or trouble swallowing  |   | Unexplained hair loss  |
|   | Eye Pain  |   | Nausea or vomiting  |   | Changing moles  |
|   | Hearing Loss  |   | Yellow skin/eyes  |   | Drinking too much  |
|   | Voice Change  |   | Black tar/blood in stools  |   | Low sex drive  |
|   | Fainting Spells  |   | Constipation  |   | Women Only  |
|   | Rapid/pounding heart  |   | Diarrhea  |   | Vaginal discharge  |
|   | Shortness of breath  |   | Trouble Emptying Bladder  |   | Pelvic Pain  |
|   | Chest Pain  |   | Blood in urine  |   | Breast Lumps  |
|   | Cough  |   | Painful urination  |   | Nipple discharge  |
|   | Blood in Sputum  |   | Urinating too frequently  |   | Men Only  |
|   | Wheezing  |   | Urinary incontinence  |   | Erectile dysfunction  |
|   | Loud Snoring  |   | Abnormal urge to urinate  |   |   |
|   | Stop Breathing in Sleep  |   | Joint Swelling  |   |   |
|   | Not well rested after full night sleep  |   | Abnormal Bleeding/Bruising  |   |   |
|   | Swelling in legs/ankles  |   | Unexplained lumps or masses  |   |   |

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**Disclaimer:** At Looking Good Cosmetic Surgery we are NOT prescribing the Brand name **Semaglutide**BUT we are prescribing the generic compounded **(Semaglutide)** injection which is an injectable prescription medicine used for adults with obesity (BMI ≥30) or overweight (excess weight) (BMI ≥27) who also have weight-related medical problems to help them lose weight and keep the weight off.

* Semaglutide should be used with a reduced calorie meal plan and increased physical activity.
* **Semaglutide**contains semaglutide and should not be used with other semaglutide-containing products or other GLP-1 receptor agonist medicines.
* It is not known if Semaglutideis safe and effective when taken with other prescription, over-the-counter, or herbal weight loss products.
* It is not known if Semaglutide can be used safely in people with a history of pancreatitis.
* It is not known if Semaglutide is safe and effective for use in children under 18 years of age.

**Do not use Semaglutide if:**

* you or any of your family have ever had a type of thyroid cancer called medullary thyroid carcinoma (MTC) or if you have an endocrine system condition called Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).
* you have had a serious allergic reaction to Semaglutide or any of the ingredients in Semaglutide**.**

**Before using Semaglutide, tell your healthcare provider if you have any other medical conditions, including if you:**

* have or have had problems with your pancreas or kidneys.
* have history of diabetic retinopathy.
* have or have had depression, suicidal thoughts, or mental health issues.
* are pregnant or plan to become pregnant. Semaglutidemay harm your unborn baby. You should stop using Semaglutide 2 months before you plan to become pregnant.
* are breastfeeding or plan to breastfeed. It is not known if Semaglutidepasses into your breast milk.

**Tell your healthcare provider about all the medicines you take,**including prescription and over-the-counter medicines, vitamins, and herbal supplements. Semaglutidemay affect the way some medicines work and some medicines may affect the way Semaglutide works. Tell your healthcare provider if you are taking other medicines to treat diabetes, including Sulfonylureas or insulin. Semaglutideslows stomach emptying and can affect medicines that need to pass through the stomach quickly.

**What are the possible side effects of Semaglutide?**

**Semaglutide may cause serious side effects, including:**

* **Possible thyroid tumors, including cancer.** Tell your healthcare provider if you get a lump or swelling in your neck, hoarseness, trouble swallowing, or shortness of breath.

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* These may be symptoms of thyroid cancer. In studies with rodents, Semaglutide and medicines that work like Semaglutide caused thyroid tumors, including thyroid cancer. It is not known if Semaglutide will cause thyroid tumors or a type of thyroid cancer called medullary thyroid carcinoma (MTC) in people.
* **inflammation of your pancreas (pancreatitis).**Stop using Semaglutideand call your healthcare provider right away if you have severe pain in your stomach area (abdomen) that will not go away, with or without vomiting. You may feel the pain from your abdomen to your back.
* **gallbladder problems.** Semaglutidemay cause gallbladder problems, including gallstones. Some gallstones may need surgery. Call your healthcare provider if you have symptoms, such as pain in your upper stomach (abdomen), fever, yellowing of the skin or eyes (jaundice), or clay-colored stools.
* **increased risk of low blood sugar (hypoglycemia) in patients with type 2 diabetes, especially those who also take medicines for type 2 diabetes such as sulfonylureas or insulin.**This can be both a serious and common side effect. Talk to your healthcare provider about how to recognize and treat low blood sugar and check your blood sugar before you start and while you take Semaglutide. Signs and symptoms of low blood sugar may include dizziness or light-headedness, blurred vision, anxiety, irritability or mood changes, sweating, slurred  speech, hunger, confusion or drowsiness, shakiness, weakness, headache, fast heartbeat, or feeling jittery.
* **kidney problems (kidney failure).**In people who have kidney problems, diarrhea, nausea, and vomiting may cause a loss of fluids (dehydration) which may cause kidney problems to get worse. It is important for you to drink fluids to help reduce your chance of dehydration.
* **serious allergic reactions.**Stop using Semaglutideand get medical help right away, if you have any symptoms of a serious allergic reaction, including swelling of your face, lips, tongue, or throat; problems breathing or swallowing; severe rash or itching; fainting or feeling dizzy; or very rapid heartbeat.
* **change in vision in patients with type 2 diabetes.**Tell your healthcare provider if you have changes in vision during treatment with Semaglutide.
* **increased heart rate**. Semaglutidecan increase your heart rate while you are at rest. Tell your healthcare provider if you feel your heart racing or pounding in your chest and it lasts for several minutes.
* **depression or thoughts of suicide.**You should pay attention to any mental changes, especially sudden changes in your mood, behaviors, thoughts, or feelings. Call your healthcare provider right away if you have any mental changes that are new, worse or worry you.

**The most common side effects of Semaglutide may include:**nausea, diarrhea, vomiting, constipation, stomach (abdomen) pain, headache, tiredness (fatigue), upset stomach, dizziness, feeling bloated, belching, gas, stomach flu and heartburn. night.Donot share your Semaglutide injections with other people, even if the needle has been changed. You may give other people a serious infection, or get a serious infection from them.

It’s better to take medication at night. Do not share your Semaglutide injections with other people, even if the needle has been changed. You may give other people a serious infection, or get a serious infection from them.

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**Semaglutide Weight Loss Program**

**Patient Intake Questionnaire**

During the last 3 months, I have had episodes of excessive overeating where I ate more than what most people would eat in a similar period of time........................................\_\_ Yes \_\_ No

* If "No", please skip to 'Other Weight Loss Program' section
* If "Yes" complete the following:

During these episodes I feel I have NO CONTROL over my eating................. \_\_ Yes\_\_ No

I eat during these episodes even when I am not hungry.................................. \_\_ Yes\_\_ No 

During these episodes I feel embarrassed by how much I ate.......................... \_\_ Yes\_\_ No 

During these episodes I feel disgusted with myself, or guilty afterward ......... \_\_ Yes\_\_ No 

In the past 3 months, I have sometimes made myself

vomit to try to control my weight........................................................................ \_\_ Yes\_\_ No

**Other Weight Loss Programs:**

I have done other weight loss programs or taken other weight loss medications.. \_\_ Yes\_\_ No

If yes, which one:

The person closest to me supports my intentions to do this program.................... \_\_ Yes\_\_ No

Long term, I would like to maintain my weight at: \_\_\_\_\_\_\_\_\_\_ lbs
I would like to achieve this goal in the following number of months: \_\_\_\_\_\_\_\_\_

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**PATIENT CONSENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Looking Good Cosmetic Surgery and staff to help me in my weight reduction efforts.

**While using semaglutide, it is highly recommended that you:**

* Eat a fibrous diet. Focus on fruits and vegetables that are high in fiber.
* Eat small high protein meals as digestion is slowed down while on this medication.
* Avoid foods high in fat as they take longer to digest.
* Limit alcohol intake as this medication can lower blood pressure.
* Drink at least 32oz of water a day to avoid constipation

**Do not use this medication if:**

* You have a personal or family history of medullary thyroid carcinoma (Thyroid Cancer)
* Multiple Endocrine Neoplasia syndrome type 2
* You are pregnant or plan to become pregnant while taking this medicine
* You are diabetic and/or taking any medications related to lowering your blood sugar levels without speaking with your endocrinologist.
* Specifically, if you are prescribed Insulin because the combination may increase your risk of hypoglycemia (low blood sugar) and dosage adjustments by your provider may be necessary.
* You have a history of Pancreatitis
* You are allergic to BPC-157, Semaglutide or any other GLP-1 agonist such as: Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®;
* If you have other allergies. This product may contain inactive ingredients, which can cause allergic reactions or other problems. Talk to your pharmacist for more details. Before using this medication, tell your doctor/pharmacist your medical history.

**Possible drug interactions:** Anti-diabetic agents, specifically: Insulin and Sulfonylureas (e.g., glyburide, glipizide, glimepiride, tolbutamide) due to the increased risk of hypoglycemia (low blood sugar). Do not take with other GLP-1 agonist medicines such as: Adlyxin®, Byetta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy® (THIS IS NOT AN ALL-INCLUSIVE LIST). Other medications used in diabetes, please tell your provider about any medications that may lower your blood sugar.

**Possible side effects:** Nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distension, belching, hypoglycemia, flatulence, gastroenteritis, and gastroesophageal reflux disease. Subcutaneous Injections: common injection site reactions characterized by itching, burning at site of administration with or without thickening of the skin(welting). If you notice other side effects not listed above, contact your doctor or pharmacist. A very serious allergic reaction to this drug is rare. However, get medical help right away if you notice any symptoms of a serious allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. Report adverse side effects to your doctor or pharmacist. In the event of any emergency, call 911 immediately.

**Consent to treatment by a physician:**

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM AND I REALIZE I SHOULD NOT SIGN THIS FORM IF ALL ITEMS HAVE NOT BEEN SATISFACTORY EXPLAINED TO ME. WITH MY SIGNATURE I ACKNOWLEDGE THAT MY QUESTIONS HAVE BEEN ANSWERED FULLY, AND THAT I HAVE BEEN REQUESTED TO READ THIS FORM AND HAVE BEEN GIVEN AMPLE TIME TO UNDERSTAND ALL ITS CONTENTS.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SEMAGLUTIDE SIDE EFFECTS AND INFORMATION**

**Side Effects Include:**

* Stomach pain
* Constipation
* Headaches
* Tiredness
* Bloating
* Dizziness
* Indigestion
* Gas pains
* Burping

**FAQ**

* Does Semaglutide interact with any other medications?
	+ Yes, Semaglutide can cause interactions with blood sugar-reducing medicines, like insulin. There is also a possibility that it causes issues with other oral medications, affecting how medications are absorbed.
* What happens if I miss one week of injections?
	+ If you miss a dose, it is imperative to get the injection as soon as possible as to not compromise your results. We do not give double doses so it is crucial to schedule your next appointment as close to the original time as possible if you can not make it.
* Do I have to exercise or diet while on the medication?
	+ A proper diet and at least 30 minutes of exercise a day can help to compliment the medication and optimize your results; however, these things are not required to see change in your body.