
# INFORMED CONSENT FOR COMPOUNDED GLUCAGON-LIKE PEPTIDE-1 AGONIST (GLP-1) MEDICATIONS

This document is intended to serve as confirmation of informed consent to receive a prescription for a compounded medication, including Glucagon-like Peptide-1 Agonist (GLP-1) Injections (Semaglutide, Tirzepatide, or Liraglutide, Retatrutide), which are prescription medications used for weight loss.

I am executing this informed consent document ("**Informed Consent**") to verify and confirm my discussion with John D. Gonzalez, DNP, APRN, ACNP-BC, ANP-C (**"Provider"**) regarding the risks, benefits, and alternatives to treatment through Holistic Integrative Health ("**Practice**"). I am here for my own purposes and not on behalf of any third-party. I understand that I am a participant in the decision-making process and I am free to decline services or treatments at any time. I agree to bring to the attention of Practice's clinical staff, if, at any time, I have any lack of understanding of such risks, benefits and alternatives, and inquire of clinical staff for further explanation until I have a full understanding before giving consent to any procedure or treatment.

## 1. Benefits of compounded glucagon-like peptide-1 agonist medications

I understand that Provider has identified GLP-1 medications as potentially beneficial for assisting me with my weight loss goals.

## 2. Risks

I understand that GLP-1 medications are not without risk. **I understand that the following possible side effects may occur.** This is not an all-inclusive list.

**Most Common Side Effects:** Nausea, Vomiting, Diarrhea, Constipation, Abdominal Pain, Headache, Fatigue, Dyspepsia, Dizziness, Abdominal Distention, Belching, Hypoglycemia, Flatulence, Gastroenteritis, Gastroesophageal Reflux Disease, Injection Site Reactions (itching or burning at site of administration with/without thickening of the skin).

**Less Common but Serious Side Effects:** [Pancreatitis (inflammation of the pancreas), hypoglycemia (low blood sugar), acute gallbladder disease including gallstones, acute kidney problems (kidney failure), serious allergic Reactions (including swelling of your face, lips, tongue, or throat, severe rash or itching, very rapid heartbeat, problems breathing or swallowing, or fainting or feeling dizzy), change in vision in people with type 2 diabetes, increase in heart rate (heart racing that lasts for several minutes), depression, or thoughts of suicide.

## RISK OF THYROID C-CELL TUMORS

This medication has been found to cause a specific type of thyroid tumor (thyroid C-cell tumors) in rats and mice. It's not known if this medication can cause similar tumors in humans. This medication should NOT be used by people with a personal or family history of medullary thyroid carcinoma (MTC) or those with

Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). While using this medication, I agree to contact Provider immediately if I notice any signs of thyroid tumors, such as an unusual growth or lump in the neck, difficulty swallowing, shortness of breath, or persistent hoarseness.

I agree to inform Practice's clinical staff of all known factors that might affect treatment, including, but not limited to, all medications, drugs, drug sensitivities and allergies, history of seizures, fits or fainting, presence of a pacemaker, bleeding disorder, use of anti-coagulants, damaged heart valves or occluded vessels, immune deficiencies, or other special risks of infection, as well as any other significant factors within my knowledge. I further agree to inform Practice's clinical staff of any disorder or state of mind that might affect my capacity to make informed health decisions, and should any such impairment exist, I will provide information regarding a surrogate decision maker.

**3. Alternatives and Responsibility to Maintain Separate Primary Care Physician**

As alternatives, Provider encourages me to speak with and consider the advice of other providers. Provider will consult with, but does not replace, care currently provided to me by other physicians or providers, such as my internist, gynecologist, cardiologist, gastroenterologist, pediatrician (in the case of children), oncologist or other specialty care provider. In addition to discussing other modes of therapy that may be used for the treatment of my condition, Provider and I have discussed, and I understand, the possibility of a referral to a specialist for my condition(s) if I have not already consulted with an appropriate specialist. Provider has advised me that he/she does not admit patients to the hospital or treat hospitalized patients.

I understand that as a condition of my treatment by Practice, I must maintain a relationship with an outside physician to act as my primary care provider and to provide emergency and urgent care. If I encounter a medical emergency and am not able to obtain care from my primary care physician(s), I will contact 911 or report to a hospital emergency department as appropriate.

**4. Medication and Responsibilities**

**I understand that certain drug interactions may occur.**

- I will not use this medication with any other product that contains semaglutide or other medications that are similar to this medication (such as tirzepatide, liraglutide, exenatide, dulaglutide, Wegovy, Ozempic, Rybelsus, Mounjaro, Zepbound, Saxenda, Victoza, Trulicity, or Retatrudide).
- I understand that, if prescribed a GLP-1 or like medication, and I take the compounded GLP1 or like medication with other medications by mouth, it might slow down how quickly my stomach empties, which could affect how well my body absorbs other medications. I will update my Provider on a complete list of my medications.
- The risk of my blood sugar dropping may be higher if I use compounded semaglutide with another medicine that can cause low blood sugar, such as sulfonylureas, insulin, Dipeptidyl peptidase-4 inhibitors (DPP-4s), and meglitinides.
- I will keep Provider updated on all the medications I am taking, including dietary supplements and over the counter medications, herbal products, or nutraceuticals.

**I have told my Provider about all of my medical conditions, including, but not limited to:**

- Any personal or family history of medullary thyroid carcinoma (MTC) or with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
- Problems with my pancreas or kidneys
- Severe problems with my stomach, including gastroparesis or problems digesting food
- Any history of diabetic retinopathy

- Am pregnant or plan to become pregnant
- Type 1 or type 2 diabetes
- History of Pancreatitis
- Gallbladder issues
- History of Eating Disorders
- Depression
- Suicidal thoughts or behavior
- History of a suicide attempt
- All Medications and supplements I am currently taking
- Known drug allergies

**I will follow any directions for use provided to me by my pharmacist or my healthcare Provider, including the following:**

- I understand this medication must be self-injected in the subcutaneous tissues (under the skin). The most common dosing is once a week but dosing and frequency may be adjusted for your individual needs.
- I understand this medication must be kept refrigerated and expires after 28 days of the initial puncture of the medication vial.
- I will notify my Provider If I experience side effects or if I am having trouble with administration.
- I will not share this medication (or needles) with others and agree to dispose of needles and excess medication safely and within 28 days of the initial puncture of medication vial.
- I will not adjust any dosage without the express instructions of my Provider.

I understand that, as with any health treatment, there is no guarantee that I will obtain satisfactory results. I have been informed that it is in my best interest to discuss potential alternative methods of treatment for my condition with my primary care physician or an appropriate specialist before, as well as during, the course of treatments. I understand the services provided by Practice do not preclude me from using other treatments as well, though I recognize that I should inform any practitioners I am seeing about the various treatments I am using. I understand that my failure to comply with any treatment recommendations will have an impact on the results of treatment.

**I understand that I must immediately inform Practice's clinical staff of any adverse effect of treatment noted, including any unanticipated pain or other negative sensation, unpleasant cognitive conditions, anxiety, depression or other negative emotions or any unpleasant taste or smell associated with the consumption of supplements or herbs.**

**I will immediately notify Practice's clinical staff in the event of pregnancy or breastfeeding, as some treatments may be contraindicated for pregnant or breastfeeding patients.**

I understand that I am responsible for disclosing to Provider all medications, care, and assessments that I receive elsewhere and to provide medical records from other providers to ensure that care is coordinated and compatible. Likewise, I am responsible for informing any other health professionals of the treatments, supplements, and/or medications I undergo with Provider and/or Practice.

I understand that Provider's treatment may include the recommendation that I seek other types of treatment from other health professionals who are not affiliated with Practice. I understand that while Provider may communicate with these professionals to explain why Provider made the recommendation, Provider does not supervise them and is not responsible for them.

NOTE: Do not sign this form unless you have read it and feel that you understand it. Ask any questions you might have before signing this form. Do not sign this form if you have taken medications which may impair your mental abilities or if you feel rushed or under pressure.

By signing below, I acknowledge and certify that I have had opportunities to ask questions and have had them answered to my satisfaction; I have read and fully understand the foregoing Informed Consent, and I have all of the knowledge I currently desire; I have discussed the issues noted above with Provider; and I agree and accept all of the terms above. I am legally competent and have sufficient knowledge to give voluntary and informed consent.

**PATIENT**

**SIGNATURE: _____ DATE: _____**

**PRINT NAME: _____**

**TITLE (if legal representative or guardian): _____**

I have explained this Informed Consent and answered all questions in layman's terms, and informed the patient of the available alternatives and of the potential risks. To the best of my knowledge, the patient has been adequately informed, comprehends the information, and has consented.

**PRACTICE**

**SIGNATURE: _____ DATE: _____**

**PRINT NAME: _____**