Semaglutide/Tirzepatide Weight Loss Program

- Semaglutide/Tirzepatide injection is a GLP-agonist (glucagon like peptide) which mimics a protein found naturally in the body but it lasts longer

- Effects are in the Gastrointestinal tract as well as the brain that diminishes appetite, food cravings, energy intake and increase satiety (feeling full)

- Considered to be a game changer in the future of weight loss management

- Patients will be screened and advised to obtain baseline blood work

- Weekly monitoring and injections will be performed in office and in special circumstances a kit can be given to you if you prefer to give your the injections at home
- Cost is $350 per month for first month

Injection SIte Reaction

- Semaglutide/ Tirzepatide is a subcutaneous injection (under the skin)
- Pain, redness, swelling, tenderness, bruising of the skin
- Intramuscular or intravascular injections are rare, but will be addressed at time of treatment, if they occur
- Infections, despite proper antiseptic technique, may occur and will be assessed thoroughly by the medical provider

I have been made aware of the possible complications [redacted](initials)

Adverse Reactions:

- Most common
    - Nausea
    - Vomiting
    - Diarrhea
    - Constipation
    - Headache
    - Fatigue
    - Dyspepsia
    - Dizziness
    - Bloating
    - Gerd

- Serious but Rare
    - Pancreatitis
    - Gallbladder problems
    - Hypoglycemia
    - Kidney injury
    - Allergic Reactions
    - Diabetic Retinopathy
    - Increased heart rate
    - Depression

I have been made aware of the possible complications [redacted] (initials)

Name: _____

Address_____

Date of Birth _____

Email _____

Important Safety Information

Indication: Desired weight loss with healthy lifestyle modifications to men and women over the age of 18

Contraindications:

- History of Medullary Thyroid Carcinoma: although only found in internal studies at high dose (rare cancer)
- History of or family history of MEN Type 2 (Multiple Endocrine Neoplasia
- Pancreatitis
- Chronic Kidney disease
- Allergies to Semaglutide or other GLP agonists or its preservatives
- Current therapy with another GLP agonist
- History of Diabetic Retinopathy
- History of bariatric surgery
- Pregnancy
- Any medical condition that the provider feels may risk complications that outweight the benefit of treatment

To the best of my knowledge I do not have or have history of these conditions:

Signature _____ Date: _____

Protocol:

Week 1: Initial assessment

- Date
- Height
- Weight
- BMI
- Weight loss goal
- Informed Consent
- Injection #1

Weight 2-5

- Monitor weekly progress
- Document weight
- Assess for adverse reactions
- Assess for Adverse Reactions
- Assess for BMI <22 (will need to discontinue program if reaches this)
- Injection #2-6, document site

Hx and Physical assessment form

Name _____ Gender_____

Allergies _____ Latex Allergy_____

HABITS
Alcohol _____

Smoking_____

Herbal Supplements_____

Medications currently taking

_____

This section to be completed by the examining healthcare provider

Past Medical/Surgical history

- ☐ DM Type 2 Diabetes
- ☐ Hypertension
- ☐ Arrhythmia
- ☐ CVA/TIA
- ☐ Asthma
- ☐ Murmur
- ☐ DVT
- ☐ ESRD
- ☐ Transplant
- ☐ Prior medication complications
- ☐ Abnormal bleeding/bruising
- ☐ CAD
- ☐ COPD
- ☐ Hyperlipidemia
- ☐ Liver Disease
- ☐ GERD
- ☐ Dialysis
- ☐ Aortic Stenosis
- ☐ CHF
- ☐ Sleep apnea
- ☐ Dementia
- ☐ Hypothyroid
- ☐ Seizure disorder
- ☐ Eating disorders
- ☐ Pacemaker

Comments _____

Signature_____ Date _____

Printed Name _____

- By signing below, I verify that the information presented to me in the semaglutide program/enrollment form is complete and accurate to the best of my knowledge.

- I understand that Ryma Aesthetics, reserves that right, at any time and for any reason, without notice to modify this enrollment form or modify/discontinue treatment.

- I have been made aware of the risks and possible complications regarding this treatment and agree that this is a voluntary procedure.

- I understand that individual results may vary and this program should be implemented with an exercise and healthy diet program for maximum results .

- I understand this medication may cause adverse side effects and 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 medications.

- I understand symptoms may be worse after there has been a change in my medication dose or when first starting the medications

- I have informed my provider of any known allergies, my medical conditions, medications, social/family history

- I understand the mechanism of action

- I understand how it is administered

- I understand that the prescription will come from a compound pharmacy, which is not FDA approved. I have been told that the manufacturing facility itself is FDA monitored along with third part testing on the medication itself

- I consent to the cost of treatment and agree to pay per month.

- In cases, where client request to inject at home, they will be responsible for the care of the product and understand that it needs to be kept in fridge at controlled temperature. Provider is not financially responsible for care of syringes after leaving office.

Signature _____

Printed Name _____

Date_____