Your Practice Name

Informed Consent for GLP-1 / GIP Receptor Agonists

Prescriber and patient complete together for the specific medication prescribed

1. Patient and prescription details

Patient full name _____ Date of birth _____

Chart / visit ID _____ Reason for treatment _____

☐ Semaglutide ☐ Tirzepatide ☐ Other medication

Exact product name and dosage form _____

☐ Subcutaneous injection ☐ Oral

Starting dose and units _____ Frequency _____

Dispensing pharmacy _____

Formulation and regulatory status (prescriber completes)

☐ FDA-approved product

☐ Compounded preparation This preparation is not FDA-approved. The FDA has not reviewed it for safety, effectiveness or quality. My prescriber explained why it is being prescribed for my individual medical need.

Patient initials _____

☐ Off-label use of an FDA-approved product

Relevant approved use _____

Intended off-label use _____

Patient initials _____

2. Boxed warning and safety screening

Thyroid C-cell tumor warning. Semaglutide and tirzepatide products carry a boxed warning. These medicines caused thyroid C-cell tumors in animals. It is unknown whether they cause these tumors in people.

Contraindications for semaglutide or tirzepatide. Tell your prescriber if you have a personal or family history of medullary thyroid carcinoma (MTC), multiple endocrine neoplasia type 2 (MEN 2), or a known serious allergy to the prescribed drug or its ingredients.

Check any items that apply or tell the prescriber if unsure. The prescriber will review contraindications and other precautions before treatment.

☐ Personal or family history of MTC or MEN 2

☐ Pancreatitis or gallbladder problems

☐ Pregnancy, plans to conceive or breastfeeding

☐ Diabetic retinopathy or vision changes

☐ Serious allergy to product or an ingredient

☐ Severe stomach problems or gastroparesis

☐ Insulin or sulfonylurea use

☐ None of these

Prescriber notes and product-specific screening _____

3. Side effects, serious risks and when to seek help

Common side effects. Nausea, vomiting, diarrhea, constipation, belly pain, indigestion and fatigue. Injections may cause a reaction where the shot is given.
Serious risks to discuss. Pancreatitis, gallbladder problems, kidney injury from dehydration, severe allergic reactions, low blood sugar (especially with certain diabetes medicines) and worsening diabetic eye disease in some patients. My prescriber reviewed the risks for my specific product.
Procedures and pregnancy. I will tell the surgical or anesthesia team about this medication before any planned procedure. Delayed stomach emptying can lead to stomach contents entering the lungs during general anesthesia or deep sedation. I will tell my prescriber if I am pregnant, breastfeeding or planning pregnancy, and discuss any effect on oral birth control and when to stop treatment before a planned pregnancy.

Patient initials _____

When to get help. Get emergency help for trouble breathing or swelling of the face, lips, tongue or throat. Seek prompt medical care for severe belly pain that does not go away, with or without vomiting, or signs of dehydration. Tell the practice promptly about a new neck lump, persistent hoarseness, trouble swallowing or changes in vision.

4. Benefits, alternatives and follow-up

Expected benefit and alternatives discussed _____
Depending on why I am taking this medicine, alternatives may include lifestyle changes, other medicines, surgery or choosing no medication. My results may vary.
Medication plan. I reviewed how to take and store this product and what to do if I miss a dose. I will check with my prescriber before changing the dose or combining it with another GLP-1 product. I will not share my medication. I understand the plan for follow-up, lab work and refills.

Patient initials _____

Product-specific instructions (e.g., injection concentration, volume or contraception) _____

Follow-up and monitoring _____ Cost and billing period (if applicable) _____

Missed monitoring or discontinuation policy, if applicable _____

5. Consent and signatures

We discussed the prescribed product, its benefits and risks, and my alternatives. I had a chance to ask questions and agree to the treatment described above.

Good Faith Exam / prescriber assessment date, if applicable _____

Patient signature _____ Date _____

Prescriber name and credentials _____

Prescriber signature _____ Date _____

Template for review. Have your medical director and healthcare counsel review it against current product labeling and state rules. Review consent again if the drug, source or route changes.