ENCOMPASS CARE

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FAX

TO: **FROM:** ENCOMPASS CARE

FAX: **PAGES:**

PHONE: **DATE:**

RE: **CC:**

___URGENT ___FOR REVIEW ___PLEASE REPLY ___PLEASE SHRED

* FIRST PACKET - TIRZEPATIDE CONSENT

* SECOND PACKET - TIRZEPATIDE INFORMATION

* TAKE SEMAGLUTIDE INFORMATION OFF WEBSITE & REPLACE WITH TIRZEPATIDE CONSENT & INFORMATION PACKET *

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Patient Consent Form for Tirzepatide Weight Loss Program

Patient Name: _____
Date of Birth: _____

This consent form is provided to ensure that you, the patient, are fully informed about the medication Tirzepatide prescribed for weight loss, including its benefits, potential side effects, and the expected course of treatment. Please review this form carefully. If you have any questions or concerns, do not hesitate to ask your healthcare provider before signing.
By signing this consent form, you acknowledge that you have been provided with adequate information regarding this medication and that you fully understand the potential risks and benefits involved.

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1. ***Description of Tirzepatide:***

Tirzepatide is a prescription medication that is used to aid in weight loss by regulating blood sugar levels and suppressing appetite. It is administered through an injection and is generally prescribed as part of a comprehensive weight management plan, including diet and exercise.
Mechanism of Action:
Tirzepatide works by mimicking two hormones, GLP-1 and GIP, which help regulate insulin secretion and appetite. It can improve glucose control and lead to reduced body weight.
2. Expected Benefits of Tirzepatide:

- ***Weight loss: Tirzepatide has shown effectiveness in reducing body weight in clinical trials. Patients can expect a reduction in hunger, cravings, and overall food intake***
  .
- ***Improved blood sugar control: This medication can help with better management of blood glucose levels, particularly in patients with prediabetes or type 2 diabetes.***

3. Possible Side Effects:

Tirzepatide may cause side effects, some of which may be serious. Common and less common side effects include:

Common Side Effects:

- *Nausea*
- *Diarrhea*
- *Vomiting*
- *Decreased appetite*
- *Abdominal pain or discomfort*
- *Constipation*

Serious Side Effects (rare but possible):

- *Pancreatitis (inflammation of the pancreas)*
- *Kidney problems or kidney failure*
- *Gallbladder disease (including gallstones)*
- *Hypoglycemia (low blood sugar)*
- *Severe allergic reactions (difficulty breathing, rash, swelling)*
- *Thyroid tumors (including medullary thyroid cancer)*

If you experience any of the following, seek immediate medical attention:

- *Severe abdominal pain*
- *Swelling in the throat or face*
- *Difficulty breathing*
- *Persistent vomiting or dehydration*
- *Signs of severe low blood sugar (shakiness, confusion, dizziness)*

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4. Administration and Monitoring

Tirzepatide is injected subcutaneously (under the skin) once a week. It is important to follow your healthcare provider's instructions on proper injection techniques and schedules.

In-Office Weekly Injection:

You are required to come to the healthcare office once a week to receive your Tirzepatide injection. It is essential that you maintain this schedule for the medication to be effective.

Monthly Monitoring with the Doctor:

You will be required to meet with your healthcare provider monthly for monitoring and assessment of your progress. During these visits, your provider will evaluate the effectiveness of the medication, check for any side effects, and ensure your health remains stable. Regular monitoring is crucial to ensure the safe and effective use of this medication.

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5. Contraindications and Precautions

Tirzepatide should not be used in the following cases:

- *If you are allergic to tirzepatide or any of its ingredients.*

- *If you have a history of thyroid cancer or multiple endocrine neoplasia syndrome type 2.*
- *If you have severe gastrointestinal disorders, including gastroparesis.*

Before starting Tirzepatide, inform your healthcare provider if you have:

- *Any history of pancreatitis*
- *Kidney or liver issues*
- *Any history of gallstones or gallbladder disease*
- *Type 1 diabetes (Tirzepatide is not approved for this condition)*
- *Any current or planned pregnancy or breastfeeding*

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6. Risks and Responsibilities

By signing this consent, you acknowledge that:

- *Understanding of Risks: You have been fully informed about the risks associated with Tirzepatide, including the possibility of severe side effects. You understand that these risks may not apply to everyone but may affect some individuals.*
- *Regular Monitoring: You agree to attend follow-up appointments and undergo necessary tests to monitor the effects of Tirzepatide on your health.*
- *Discontinuing Medication: You understand that if you experience any serious side effects or are unsatisfied with the results, you should consult your healthcare provider immediately to determine whether to continue the medication.*

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7. Agreement of Non-Liability:

By signing this consent form, you agree that:

- *Informed Decision: You have been fully informed about the treatment plan, including the medication, its potential side effects, and the expected benefits. You understand the potential risks associated with Tirzepatide.*
- *No Legal Action: You acknowledge that the prescribing physician and associated healthcare team have adequately explained the treatment and potential risks and that, by proceeding with treatment, you agree not to hold the physician or healthcare provider liable for any adverse effects arising from the use of Tirzepatide, except in cases of medical malpractice or negligence.*

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8. Consent for Treatment

I, the undersigned, hereby give my informed consent to start treatment with Tirzepatide for weight loss as prescribed by my healthcare provider. I understand that this consent is voluntary and that I can withdraw my consent at any time by notifying my healthcare provider.

I understand the purpose of the medication, its potential side effects, and my responsibilities regarding regular monitoring and follow-up visits. I understand that the results may vary, and the decision to proceed with this treatment is based on my individual medical history and health profile.

Patient Signature: _____

Date: _____

Medical Assistant signature: _____

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Indemnification Clause

Indemnification Agreement

By signing this consent form, the undersigned patient or client (hereafter "Patient") agrees to indemnify, defend, and hold harmless **Encompass Care**, its officers, employees, agents, contractors, and affiliated entities (collectively referred to as "Encompass Care") from and against any and all claims, actions, suits, losses, damages, liabilities, costs, expenses (including attorneys' fees), or judgments arising from or in any way related to the Patient's participation in any treatment, procedure, or service provided by **Encompass Care**. This includes, but is not limited to, any claims related to:

1. **Medical Complications:** Any injuries, adverse reactions, side effects, or complications resulting from the treatments or services provided by **Encompass Care**, including those that may occur during or after treatment.
2. **Negligence or Errors:** Claims based on alleged negligence, errors, or omissions in the provision of care, provided that such negligence is not a result of willful misconduct by **Encompass Care** or its employees.
3. **Third-Party Claims:** Any claims brought against **Encompass Care** by third parties that arise as a result of the Patient's actions or conduct during the course of their treatment or care.
4. **Violation of Law:** Any claims resulting from the Patient's failure to comply with applicable laws, regulations, or medical instructions that may lead to harm or legal repercussions.
5. **Payment and Fees:** Any claims, disputes, or legal actions arising from the payment, non-payment, or dispute over the treatment costs and fees associated with the services rendered by **Encompass Care**.

This indemnification applies whether the claims arise from actions, omissions, or decisions made by **Encompass Care**, its staff, contractors, or other affiliates, except in cases of gross negligence, willful misconduct, or fraud on the part of **Encompass Care**.

The Patient further acknowledges that they are aware of the voluntary nature of the treatment they are receiving and agree to hold **Encompass Care** harmless from any outcomes, whether favorable or adverse, resulting from their participation in the services or procedures offered.

Patient's Signature: _____

Date: _____

Medical Assistant Signature: _____