



GLP 1 Therapy Pre Consultation Form

Medical intake, safety screening, compounding assessment, and informed consent

Complete this form before your consultation. Your answers help the clinician evaluate safety and medical appropriateness. Completing or signing this form does not guarantee that treatment will be prescribed.

Patient Information

Full legal name

Date of birth

Phone

Email

Primary care clinician

Preferred pharmacy

Reason for Consultation

☐ Weight management

☐ Type 2 diabetes or prediabetes

☐ Cardiometabolic risk reduction

☐ Obstructive sleep apnea

☐ Other

Current weight

Height

Goal weight

Last blood pressure

What have you previously tried for weight management, and what happened?

Prior GLP 1 treatment

☐ Never used

☐ Semaglutide

☐ Tirzepatide

☐ Liraglutide

☐ Other

☐ No prior side effects

☐ Nausea

☐ Vomiting

☐ Diarrhea

☐ Constipation

☐ Abdominal pain

☐ Reflux

☐ Dehydration

☐ Other

Medication, dose, duration, benefit, side effects, and reason stopped



Medical Safety Screening

Check Yes for any current or past condition. A Yes answer does not automatically exclude treatment, but it requires clinician review.

- | | |
|---|---|
| ☐ Personal or family history of medullary thyroid carcinoma | ☐ Multiple endocrine neoplasia syndrome type 2 |
| ☐ Pancreatitis | ☐ Gallstones or gallbladder disease |
| ☐ Gastroparesis, bowel obstruction, or severe gastrointestinal disease | ☐ Kidney disease, dialysis, or prior dehydration-related kidney injury |
| ☐ Liver disease | ☐ Type 1 diabetes |
| ☐ Diabetic retinopathy or significant vision changes | ☐ Low blood sugar episodes |
| ☐ Eating disorder or severe food restriction | ☐ Depression, suicidal thoughts, or prior suicide attempt |
| ☐ Planned surgery, procedure, or anesthesia | ☐ Pregnant, trying to become pregnant, or breastfeeding |
| ☐ Allergy or serious reaction to a GLP 1 medication | |

Explain every item checked above

Current medications

- | | |
|--|--|
| ☐ Insulin | ☐ Sulfonylurea such as glipizide or glyburide |
| ☐ Another GLP 1 or weight-loss medication | ☐ Medication that slows stomach emptying |
| ☐ None of these | |

List all prescriptions, over-the-counter medicines, supplements, and allergies

Recent Results Available

Upload available results. Not every test is required for every patient; the clinician will determine what is necessary.

- | | |
|--|---|
| ☐ Hemoglobin A1c | ☐ Fasting glucose |
| ☐ Comprehensive metabolic panel | ☐ Creatinine and eGFR |
| ☐ Liver tests | ☐ Lipid panel |
| ☐ TSH | ☐ Pregnancy test if applicable |



☐ No recent results

Date of most recent labs

Where completed

Compounded Medication Assessment

Compounded medication is considered only when the clinician identifies a patient-specific medical need that cannot appropriately be met by an available FDA-approved product. Cost or preference alone may not establish a clinical need.

- | | |
|---|--|
| ☐ Documented allergy or intolerance to an ingredient in an available product | ☐ Clinically necessary strength or titration not commercially available |
| ☐ Clinically necessary dosage form not commercially available | ☐ Available FDA-approved product is not medically appropriate for another patient-specific reason |
| ☐ No patient-specific reason identified | ☐ Other |

Describe the exact ingredient, dosage-form issue, prior intolerance, or other patient-specific need

Patient Acknowledgment and Consent

Please initial each statement in Vagaro or select each required acknowledgment before signing.

- ☐ I understand that GLP 1 therapy commonly causes nausea, vomiting, diarrhea, constipation, abdominal discomfort, reflux, and decreased appetite.
- ☐ I understand serious risks may include pancreatitis, gallbladder disease, dehydration and kidney injury, severe gastrointestinal problems, hypoglycemia when combined with certain diabetes medicines, allergic reaction, and complications related to delayed stomach emptying, including around anesthesia or procedures.
- ☐ I understand that semaglutide and tirzepatide products carry warnings concerning thyroid C cell tumors observed in animals and must not be used with a personal or family history of medullary thyroid carcinoma or MEN 2.
- ☐ I will notify the clinician before surgery or anesthesia and immediately report severe or persistent abdominal pain, repeated vomiting, inability to keep fluids down, signs of allergic reaction, significant vision changes, severe mood changes, or pregnancy.
- ☐ I understand compounded drugs are not FDA approved and FDA does not review them before marketing for safety, effectiveness, or quality. Dosing errors, contamination, too much or too little active ingredient, treatment failure, and unexpected adverse effects are possible.
- ☐ I understand alternatives include nutrition and activity interventions, behavioral treatment, FDA-approved medications when appropriate, bariatric evaluation, or no medication. Results are not guaranteed.

Signatures

By signing, I confirm that I have read this form, answered truthfully, had an opportunity to ask questions, and voluntarily consent to the evaluation and any treatment specifically ordered after consultation. I may decline or withdraw consent before treatment. I understand that this acknowledgment does not waive rights that cannot legally be waived or excuse negligent or unlawful conduct.



Patient full legal name

Date of birth

Patient signature

Date and time

If signed by a legally authorized representative:

Representative name

Relationship or authority

Representative signature

Date and time

Clinician Use Only

☐ Consultation completed in person

☐ Consultation completed by telehealth

☐ Identity verified

☐ Medication reconciliation completed

Blood pressure

Heart rate

Weight

BMI

Pertinent history, examination, and assessment

Diagnosis or treatment indication

☐ Not a candidate

☐ Additional records or testing required

☐ Candidate after shared decision-making

☐ Referred for additional evaluation

Patient-specific medical necessity and rationale for any compounded preparation

Selected medication, formulation, dose, monitoring plan, and follow-up

I independently reviewed the information above, completed an appropriate clinical evaluation, discussed material risks, benefits, alternatives, and uncertainties, and determined whether GLP 1 therapy is medically appropriate. The patient form alone was not used as a substitute for clinical judgment.

Clinician name and credentials _____ Clinician signature _____ Date and time _____