



Peptide Therapy Pre Consultation Form

Medical intake, investigational treatment 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

Treatment Goals

- | | |
|--|--|
| ☐ Body composition | ☐ Recovery or tissue symptoms |
| ☐ Sleep | ☐ Energy or metabolic health |
| ☐ Cognitive or focus concerns | ☐ Skin or cosmetic goals |
| ☐ Inflammatory or gastrointestinal concerns | ☐ Other |

Describe the condition or goal, duration, prior evaluation, and treatments already tried

Therapies Being Discussed

- | | |
|---|--|
| ☐ Tesamorelin | ☐ Sermorelin |
| ☐ CJC 1295 plus ipamorelin | ☐ BPC 157 plus TB 500 |
| ☐ KPV | ☐ Semax |
| ☐ Epitalon | ☐ MOTS c |
| ☐ TB 500 | ☐ NAD plus |
| ☐ Glutathione | ☐ GHK Cu plus Argirelox |
| ☐ Other | ☐ No preference; clinician recommendation requested |



Medical Safety Screening

- | | |
|---|--|
| ☐ Current or prior cancer, tumor, or unexplained mass | ☐ Pituitary disease or prior pituitary treatment |
| ☐ Diabetes, prediabetes, insulin resistance, or recurrent low blood sugar | ☐ Cardiovascular disease, arrhythmia, edema, or uncontrolled blood pressure |
| ☐ Kidney disease | ☐ Liver disease |
| ☐ Severe sleep apnea | ☐ Carpal tunnel syndrome or significant nerve symptoms |
| ☐ Autoimmune or inflammatory disease | ☐ Current infection or impaired immunity |
| ☐ Seizure, serious neurologic, or psychiatric condition | ☐ Pregnant, trying to conceive, or breastfeeding |
| ☐ Recent surgery or planned procedure | ☐ Prior reaction to an injectable or compounded product |
| ☐ Use of growth hormone, IGF 1 therapy, insulin, anticoagulant, immunosuppressant, or cancer therapy | |

Explain every item checked above

List all medications, supplements, allergies, and products obtained outside a licensed pharmacy

Recent Results Available

Upload available results. Testing depends on the selected therapy, indication, and medical history.

- | | |
|---|---|
| ☐ CBC | ☐ CMP |
| ☐ Creatinine and eGFR | ☐ Liver tests |
| ☐ A1c or fasting glucose | ☐ Lipid panel |
| ☐ TSH | ☐ IGF 1 when a growth-hormone pathway is considered |
| ☐ Pregnancy test if applicable | ☐ Cancer screening information appropriate to age and risk |
| ☐ No recent results | |



Compounding and Regulatory Acknowledgment

Many products marketed as peptides for wellness, recovery, body composition, cognition, or healthy aging are not FDA approved for those uses; some are not FDA approved for human use at all. Human safety and effectiveness data may be limited or absent. FDA has identified safety concerns for certain bulk peptide substances, including immunogenicity and peptide-related impurities.

- | | |
|--|---|
| ☐ Documented patient-specific formulation need | ☐ Clinically necessary strength not commercially available |
| ☐ Clinically necessary dosage form not commercially available | ☐ Clinically necessary combination determined after evaluation |
| ☐ No FDA-approved therapy appropriately meets the identified need | ☐ No patient-specific reason identified |
| ☐ Other | |

Describe the diagnosis, prior therapy, and exact patient-specific clinical difference

Patient Acknowledgment and Consent

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

- ☐ I understand the proposed therapy may be investigational or prescribed off label and may lack adequate controlled human studies for my goal. Expected benefits, optimal dose, interactions, and long-term effects may be unknown.
- ☐ I understand potential risks may include injection-site reactions, infection, allergic or immune reactions, headache, dizziness, nausea, fatigue, fluid retention, joint or nerve symptoms, blood-glucose changes, blood-pressure or heart-rate changes, laboratory abnormalities, and unexpected or currently unknown effects. Risks vary by the selected product.
- ☐ I understand therapies affecting growth-hormone or IGF 1 pathways may influence glucose regulation, fluid retention, joint or nerve symptoms, and tissue growth and may be inappropriate with active malignancy or other conditions identified by the clinician.
- ☐ I understand compounded drugs are not FDA approved and FDA does not review them before marketing for safety, effectiveness, quality, strength, or purity. Peptide products may also present risks from degradation, aggregation, immunogenicity, impurities, contamination, or dosing error.
- ☐ I will obtain the medication only from the pharmacy selected or approved by the prescriber, will not share it, will follow storage and administration instructions, and will report adverse effects and outside products promptly.
- ☐ I understand alternatives include established treatment for the diagnosed condition, physical therapy or rehabilitation, nutrition and sleep interventions, FDA-approved medication when appropriate, specialist referral, or no treatment. Benefits are not guaranteed, and the clinician may decline or discontinue therapy.



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 peptide or investigational compounded 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 _____