DR. CAROLINA PRADERIO

Patient: ______________________________ D.O.B.: ______________

Medication:

☐ Tirzepatide	☐ 2.5 mg	Qty: ________
Lot#: ______________	☐ 5.0 mg	Qty: ________
	☐ 7.5 mg	Qty: ________
	☐ 15 mg	Qty: ________
☐ Semaglutide	☐ .25 mg	Qty: ________
Lot#: ______________	☐ .50 mg	Qty: ________
	☐ .75 mg	Qty: ________
	☐ 1.0 mg	Qty: ________

Patient to fill out details below and sign below:

I acknowledge that I have received the medication listed above in the quantity stated. I understand and accept full responsibility for storing, transporting, and administering this medication safely.

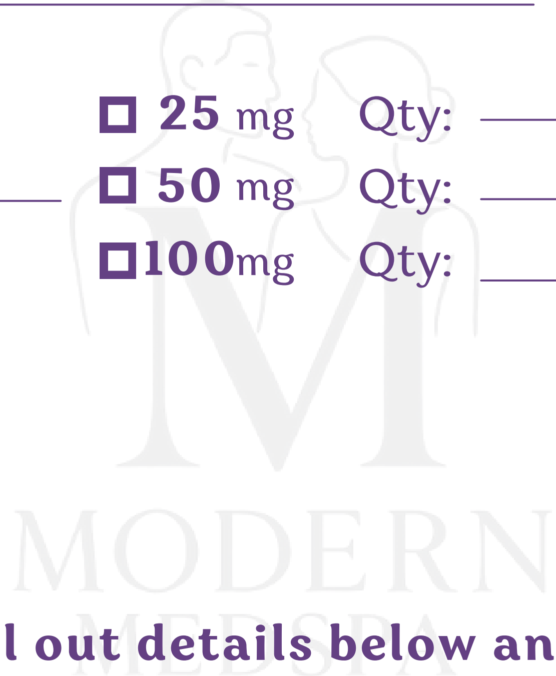
I agree to keep all syringes secure and out of reach of others, and to dispose of used or unused syringes according to proper medical-waste guidelines. I understand that the clinic is not responsible for loss, misuse, improper storage, or improper disposal once the medication has been released to me.

Signature: ______________________________ **Date:** ______________

M MODERN

DR. CAROLINA PRADERIO

Patient: ______________________________ D.O.B.: ____________



- ☐ NAD+
  Lot#: ____________

- ☐ **25** mg Qty: ________
- ☐ **50** mg Qty: ________
- ☐ **100**mg Qty: ________

Patient to fill out details below and sign below:

I acknowledge that I have received the medication listed above in the quantity stated. I understand and accept full responsibility for storing, transporting, and administering this medication safely.

I agree to keep all syringes secure and out of reach of others, and to dispose of used or unused syringes according to proper medical-waste guidelines. I understand that the clinic is not responsible for loss, misuse, improper storage, or improper disposal once the medication has been released to me.

Signature: ______________________________ **Date:** ____________

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