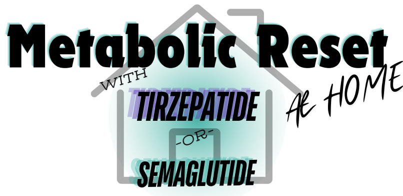

BY: DR. CAROLINA PRADERIO

Patient: ______________________ D.O.B.: ____________

Chart#: ____________

Medication:

☐ Tirzepatide		☐ Semaglutide		☐ NAD+	
Lot#: ____________		Lot#: ____________		Lot#: ____________	
☐ **2.5** mg	Qty: _____	☐ **.25** mg	Qty: _____	☐ **25** mg	Qty: _____
☐ **5.0** mg	Qty: _____	☐ **.50** mg	Qty: _____	☐ **50** mg	Qty: _____
☐ **7.5** mg	Qty: _____	☐ **.75** mg	Qty: _____	☐ **100**mg	Qty: _____
☐ **15** mg	Qty: _____	☐ **1.0** mg	Qty: _____	☐ ____mg	Qty: _____
☐ ____mg	Qty: _____	☐ ____mg	Qty: _____		

Patient to read and sign below:

I acknowledge that I have received the medication listed above in the quantity indicated. I understand and accept full responsibility for the safe storage, transportation, handling, and administration of this medication once it has been released to me.

I confirm that I have received instruction on proper Intramuscular (IM) injection technique, including appropriate injection sites, sterile injection practices, safe handling of needles and syringes, and proper sharps disposal. I understand that this medication must only be administered as directed by my healthcare provider, and I agree not to alter the prescribed dosage or frequency unless instructed to do so.

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I understand the risks associated with IM injections, including pain, bruising, bleeding, infection, allergic reaction, or injury due to improper administration. I agree to follow all instructions provided and to seek medical attention if I experience concerning symptoms or adverse reactions.

I agree to keep all medications, syringes, needles, and related supplies secure and out of reach of others, and to dispose of used or unused sharps according to proper medical waste guidelines.

I understand that once the medication has been dispensed to me, the clinic and its providers are not responsible for loss, misuse, improper storage, improper administration, sharing of medication, or improper disposal of the medication or related supplies.

Signature: ______________________________ **Date:** ____________