**Patient Consent Form**

**Tirzepatide Treatment**

**Patient Information**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Introduction**

You are being asked to participate in a treatment involving Tirzepatide, a medication used to manage blood sugar levels in adults with type 2 diabetes. This form provides information about the treatment, potential benefits, risks, and your rights as a participant.

**Purpose of the Treatment**

Tirzepatide is a dual agonist that helps improve blood sugar control by stimulating insulin secretion and reducing sugar production in the liver. It is used to lower HbA1c levels and promote weight loss in patients with type 2 diabetes.

**Description of the Treatment**

If you agree to participate, you will receive Tirzepatide according to the following protocol:

* **Dosage**: [Specify dosage, typically once weekly]
* **Administration Method**: Subcutaneous injection
* **Duration of Treatment**: [Specify duration]

**Potential Benefits**

The potential benefits of Tirzepatide treatment may include:

* Improved blood sugar control
* Weight loss
* Reduction in the risk of heart-related complications

**Potential Risks and Side Effects**

Possible risks and side effects of Tirzepatide may include, but are not limited to:

* Nausea
* Vomiting
* Diarrhea
* Hypoglycemia (low blood sugar)
* Pancreatitis (inflammation of the pancreas)

**Voluntary Participation and Withdrawal**

Your participation in this treatment is voluntary. You have the right to refuse or discontinue the treatment at any time without penalty or loss of benefits to which you are otherwise entitled. If you decide to withdraw, you should inform your healthcare provider immediately.

**Confidentiality**

All information collected about you during this treatment will be kept confidential. Your identity will not be disclosed in any reports or publications resulting from this treatment.

**Alternatives**

If you choose not to participate in this treatment, your healthcare provider will discuss alternative treatment options with you.

**Consent**

By signing this form, you acknowledge that you have read and understood the information provided, have had the opportunity to ask questions, and agree to participate in the treatment with Tirzepatide.

**Patient’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Provider’s Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**

If you have any questions or concerns about the treatment, please contact:

**Healthcare Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_