NEW PATIENT FORM

Patient Name________________________________ Date of Birth__________________

Referred by: ____

Pathfinder Healthcare

Which treatments are you interested in?

☐ Semaglutide ☐ IV Hydration ☐ Ketamine Infusion ☐ Other, please specify: ___________

Information

Mailing Address____

Phone # _____________________________Email ____

Preferred method of contact : ☐ Phone ☐ Email ☐ Text

Race: ❑ African American ❑ Alaska Native ❑ American Indian ❑ Caucasian ❑ Hispanic or Latino ❑ Native American ❑ Other

Emergency Contact Information

Name ___________________________ Relationship_________________ Phone ______________

Medical Information

Primary Care Provider_________________________Phone______________ Last Seen______________

Social History

Marital Status (please choose) ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Domestic Partnership

Do you use tobacco products? ❑ Yes ❑ No Type? ______________ How often? ______________

Do you drink alcohol? ❑ Yes ❑ No Type? ______________ How often? ______________

Do you use recreational drugs? ❑ Yes ❑ No Type? ______________ How often? ______________

Pharmacy Preference

Pharmacy Name ______________________________Address______________________________

NEW PATIENT FORM

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Allergies - Please list any allergy or intolerance you have to medications or environment (i.e. dust, nuts, animals)	
Medication or Environmental Issue	Reaction

Current Medications - Include all prescription and non-prescription (over-the-counter) medications			
Medication Name	Dose (mg, mcg, %)	How Often?	Prescriber

If you are not currently taking any medications (prescription or over-the-counter), check here ❑

Health Conditions/Concerns		
Personal or Family History of Medullary Thyroid Cancer	☐ YES	☐ NO
Personal history of Endocrine Neoplasia Syndrome	☐ YES	☐ NO

Past Surgeries/Procedures - List Type	Year

Family History - List which relative (i.e. mother, father, brother, sister, aunt, uncle, maternal/paternal grandparent, etc.)		
Illness	Family Members (please list)	If grandparent, maternal or paternal?
Cancer - Type?		
Dementia		
Diabetes - Type?		
High Blood Pressure		

Signature____ **Date**______________________________

Pathfinder Healthcare

231 S. Transit St
Suite 104
Lockport, NY 14094

Patient Name________________________________ Date of birth____________________

I do hereby agree and give consent to Pathfinder Healthcare to furnish medical care and treatment considered necessary and proper in diagnosis or treating my physical or mental condition. I understand that my care team may include a Registered Nurse or a Licensed Practical Nurse who will assist with my plan of care.

Signature____ Date__________________

Patient Privacy Policy Effective Date: April 1, 2023

The Right to Obtain a Copy of this Notice. You have the right to a paper copy of this notice at any time. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask at registration or contact our Privacy Officer at the address or phone number located at the end of this document. You may obtain a copy of this notice by requesting via our website at PathfinderHealthcare.org or requesting from any of our office staff.

Your Rights Regarding Your Protected Health Information. We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for your PHI we already have as well as any information we receive in the future. We will post a copy of the current notice. The notice will always contain on the first page, the effective date of the Privacy Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us and the Secretary of the Department of Health and Human Services. All complaints must be in writing and sent to the address provided below. You will not be penalized for filing a complaint.

Contact Information

If you require further information about this Notice, have privacy issues or believe that your privacy rights have been violated, please contact:

Pathfinder Healthcare
Attn: Privacy Officer
231 S. Transit St Suite 104
Lockport, NY 14094

Effective Date

This Notice is effective April 1, 2023.

By signing this document, I acknowledge that I have read and understood this Privacy Notice and that a copy of Pathfinder Healthcare Privacy Notice was offered to me.

______________________________	______________________________
Patient Signature	Date
Print Name	Patient Date of Birth

Semaglutide is a product utilized for safe, consistent weight loss. It is important to have REALISTIC expectations. In general, patients can expect to lose **15%** (OR MORE) of their current weight in a **6-month period** of time. During the initial 1-2 months, the goal of the program is to become accustomed to the medication and allow your body to safely become acclimated over a 4-week period.

For example:

WEIGHT: 200 pounds.
EXPECTED WEIGHT LOSS OVER 6 MONTHS: 30 pounds
EXPECTED WEIGHT LOSS PER WEEK: 1.25 pounds

FOR BEST RESULTS:

When you initiate the medication, your body is adjusting, especially during the first week. This is why side effects are most common during the first week. Many patients experience a significant amount of weight loss in the first week as well as a significant lack of hunger. During subsequent weeks your body adjusts to the medication. Until you are receiving higher dosages it is common for hunger to return, and your side effects to lessen or disappear. You will likely continue to lose weight even after your body has made this adjustment.

For this reason, during the first month early dosage increases will only be considered if you do not lose at least 2 pounds a week, and you are not experiencing any side effects. For patient safety, no early increases will be approved after the first month.

Please remember, the starting dose of 0.25mg is 10 times LESS than the expected maintenance dose of 2.4 mg. Increasing the medication too early can lead to increased side effects because your body has not had the necessary time to adjust to each dose. Rushing your weight loss by increasing doses early can negatively affect your success by causing unwanted and unmanageable side effects.

While many individuals experience significant weight loss without changing their diet and exercising, this result cannot be guaranteed. For best results this medication should be used in combination with moderate exercise and a healthy diet.

I HAVE READ AND AGREE TO THE ABOVE:

____

Signature   Date