PGD Patient Consultation Form Weight Management

This form is designed to be used as a guide during a face to face consultation.

Client Demographic Details

Name		**Sex**	
DOB		**Age**	
Phone		**Email**	
Address			
GP Surgery		**Consent to share information with GP if required**	Yes/No

Clinician has checked correct details/ID for client*	Yes/No
Consent to storage of health information	Yes/No

**Good practice to check that contact details are correct and current.*

Consent for Consultation and Treatment

Client is able to consent			Yes/No
Client is accompanied by someone able to consent on their behalf* *(Mother, father or other adult with parental responsibility, legal guardian or person with lasting power of attorney).			Yes/No/NA
Details of person consenting on behalf of another			
Name		Relationship / legal status	
Address			
The client is happy to go ahead with the consultation and treatment. The clinician will explain the recommended treatment, including relevant benefits, potential side effects, and appropriate measures for managing any adverse reactions.			Yes/No

Please answer the following questions accurately	**Please tick**	**If yes, please give details**
Do you have any allergies?	Yes ☐ No ☐	
Are you pregnant or breastfeeding?	Yes ☐ No ☐	
Do you have diabetes or prediabetes?	Yes ☐ No ☐	
Have you been told that you have high blood pressure?	Yes ☐ No ☐	
Have you been told that you have high cholesterol?	Yes ☐ No ☐	
Have you ever had any problems with your kidneys or liver?	Yes ☐ No ☐	
Have you ever been diagnosed with heart failure?	Yes ☐ No ☐	
Have you ever had pancreatitis?	Yes ☐ No ☐	

Do you have epilepsy or a history of seizures?	Yes ☐ No ☐	
Have you ever been diagnosed with an eating disorder?	Yes ☐ No ☐	
Do you have inflammatory bowel disease or gastroparesis?	Yes ☐ No ☐	
Have you ever been diagnosed with a mental health disorder?	Yes ☐ No ☐	
Do you have polycystic ovarian syndrome or Cushing's syndrome?	Yes ☐ No ☐	
Do you currently have any problems with your gall bladder?	Yes ☐ No ☐	
If you have any other medical conditions, please give details below:		
Current medications prescribed by a doctor, or bought over the counter from a pharmacy:		
Consent & Declaration		

☐ I have answered the questions above accurately and received information about my treatment

☐ I agree to take the supplied medication only as directed

☐ I agree to notify my pharmacist/clinician of any changes to my medical health

Signed Date

Name of patient

Date of consultation

For professional use only		
Patient Height (cm):	Starting Weight (kg):	Starting BMI (kg/m²):
Blood Pressure:	Heart Rate:	Goal Weight (kg):

Details of weight loss medication supplied under PGD:	Name/Brand:	
	Strength:	
	Dose:	Frequency:
	Quantity supplied:	
	Batch number and expiry:	

If starting BMI is between 27 and 30 mg/m², document justification/weight-related medical condition(s):

I can confirm the following:

- ☐ Treatment has been supplied in accordance with the PGD
- ☐ Advice has been given on managing side effects and reducing risk of dehydration/associated complications
- ☐ Monitoring appointment has been scheduled
- ☐ Reason if treatment was not supplied (give details below)

Additional information/Notes:

Cost of treatment to patient	Paid? Yes ☐ No ☐	
Name of registered healthcare professional	Signature	Date

Use copies of this page to make records of future consultations