PGD Patient Consultation Form General Medication/Vaccination

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*	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

Reason for today's appointment

Medical History. Use this information with the PGD document to decide if treatment can be supplied / administered. Refer to the GP/specialist if needed. *Note that some of this information will not necessarily exclude treatment, but will provide a better understanding of the patient. It may influence advice provided during the consultation.*

Is client fit and well today?	Yes/No
Does the client have any allergies?	Yes/No
Is the client pregnant or breastfeeding?	Yes/No
Does the client have any of the following:	
• blood or clotting disorders	Yes/No

• kidney or liver problems	Yes/No
• heart or lung problems	Yes/No
• diabetes	Yes/No
• epilepsy or neurological condition	Yes/No
• mental health condition (depression anxiety other)	Yes/No
• disability or mobility problems	Yes/No
• other condition requiring regular treatment from GP or specialist	Yes/No
If the patient is attending for an injection or vaccination:	
• does the client have any allergies, particularly to eggs or chicken protein?	Yes/No
• has the client ever had a reaction to any vaccination or a history of fainting?	Yes/No
Details if yes to any of the above or if client is currently unwell	
Current Medications – Include over-the-counter remedies and contraception	

Treatment Supplied/Administered

Medication/injection/vaccine	Quantity	Manufacturer	Batch No	Expiry Date	Route	Site

Advice Given

Details of Registered Healthcare Professional completing the consultation

Name	Qualification	Signature	Date