|  |  |  |  |
| --- | --- | --- | --- |
| Title: Mr. Mrs. Miss Ms. Other | D.o.B.: \_ \_ / \_ \_ / \_ \_ | | Age: \_\_\_\_\_\_\_\_ |
| Name: | | Home Address | |
| Surname: | |
| Email: | | Name & Address of GP (optional)  Would you like your GP to be informed of this consultation? | |
| Telephone: | |
| **Please answer the following questions** | | | |
| I consent to undertaking a remote consultation | | YES / NO | |
| Patient’s current blood pressure: | | Patient’s BMI: | |
| Do you have any allergies?  *If yes, please describe the allergy/reaction* | | Are you aware of any hypersensitivity to Liraglutide? | |
| Are you currently being treated with other weight management products? | | Are you taking any other GLP-1 receptor antagonists? | |
| Are you pregnant, planning pregnancy or is there a possibility you may be pregnant? | | Are you currently breast-feeding? | |
| **Do you suffer from any of the following?**   * Diabetic gastroparesis. * Inflammatory bowel disease. * Ketoacidosis. * Congestive heart failure. * Obesity secondary to endocrinological or eating disorders or to treatment with medicinal products that may cause weight gain. * Severe renal impairment. * Severe hepatic impairment. * Pancreatitis. | | Do you or have you suffered from any kind of eating disorder? | |
| 1. Are you worried about how you look? (**Yes/No)**; If you are, do you think about your appearance problems a lot and wish you could think about them less? **(Yes/No)** 2. How much time per day, on average, do you spend thinking about how you look? 3. Less than 1 hour a day 4. 1-3 hours a da 5. More than three hours a day 6. Is your main concern with how you look that you aren’t thin enough or that you might become too fat? **(Yes/No)** How has this problem with how you look affected your life? 7. Has it often upset you a lot? **(Yes/No)** 8. Has it often gotten in the way of doing things with friends, your family, or dating? **(Yes/No)** 9. Has it caused you any problems with school or work? **(Yes/No)** 10. Are there things you avoid because of how you look? **(Yes/No)** | | | |
| Please list all your current prescription medication including any medication you buy over the counter. | | | |
| Please provide details of any recent or past medical history of note. | | | |
| **PATIENT CONSENT**  I have received information on the risks and benefits of the treatment, and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the treatment being given.  YES / NO  I consent to my GP being contacted to request my most recent blood test results / BMI calculation to be shared for the purpose of safe treatment, where approrpiate.  YES / NO  **Signature of patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **HEALTHCARE PROFESSIONAL USE ONLY** | | | | | | | |
| Drug brand, batch number and expiry date. | | | Date | | | Cost | |
|  | | |  | |
| I confirm that the patient is not contraindicated based on the information provided by the PGD □ | | | | | | | |
| I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur □ | | | | | | | |
| I have provided the patient with an information leaflet (PIL) for the treatment I am administering, and advised them to read it □ | | | | | | | |
| I have demonstrated the correct use of the Liraglutide pen, and the patient is confident in its use □ | | | | | | | |
| Do you suspect BDD? YES / NO    You should suspect BDD if the patient answers yes to Question 1; (b) or (c) to Question 2; yes to any part of Question 3 and yes to Question 4 | | | | | | | |
| Healthcare Professional Name | | | | | Signature | | |
| **HEALTHCARE PROFESSIONAL USE ONLY** | | | | | | | |
| **Date** | **Body Mass Index** | **Blood Pressure** | | **Additional Notes**  Indicate how each reading was verified i.e. confirmed from GP, home measurement or public equipment i.e. pharmacy or gym | | | **Photo of reading has been confirmed & kept with records** |
|  |  |  | |  | | | YES / NO |
|  |  |  | |  | | | YES / NO |
|  |  |  | |  | | | YES / NO |
|  |  |  | |  | | | YES / NO |
|  |  |  | |  | | | YES / NO |
|  |  |  | |  | | | YES / NO |