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| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **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 |