Hair Loss I PGD Risk Assessment Form

Date: _ _ / _ _ / 2 0 _ _

Patient's personal details	
Title: Mr: □ Miss: □ Ms: □ Mrs: □ Dr: □	Patient Address:
First Name:	NHS No. (if known):
Last Name:	GP Name and Address:
Telephone:	GP Telephone (if known):
Gender: Male: □ Female: □ D.O.B: ___ ___/ ___ ___ / ___ ___ ___ ___ Age:	Would you like us to send a copy of this consultation to your GP? □

Patient's personal details			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Do you have any recent or past medical history of note?	☐	☐	
Do you take any current or repeat medicines? Creams? Other topicals?	☐	☐	
Have you had a serious reaction to any hair loss medicines before?	☐	☐	
Current Health			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Do you suffer from any scalp conditions (such as fungal infections)?	☐	☐	
Have you had any rapid weight loss in the past 6 months?	☐	☐	
What symptoms are you experiencing?			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Is the progression of your hair loss symmetrical (the same on the right as on the left side of your scalp)?	☐	☐	
Is the hair loss only located at the temples or the side of the forehead? Is there any associated redness or inflammation to the scalp?	☐	☐	
Is your hair loss in clumps / patches? Is the hair loss rapid?	☐	☐	
Further information about Finasteride 1mg…			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Do you understand that regrowth of hair can take up to 6 months and is most effective up to 2 years?	☐	☐	
Do you understand that any hair growth may be lost 6-12 months after treatment?	☐	☐	
GP notification…			
Tick which of the following applies to you…	***Yes***	***No***	***Details (reconfirm each appointment)***
Do you agree to tell your doctor or pharmacist about any side effects you may be experiencing with the medicines and any progression of symptoms? And have a comprehensive review in 2 years from the initial supply?	☐	☐	
Finasteride 1mg like many other medicines can interact with other medicines you may take; in this respect we recommend that you notify your doctor. Do you agree?	☐	☐	

Write below any further information which may be relevant e.g. medicines taking, conditions, concerns...

For Offical Use

Initial consultation

Date	Medicine	Qty	Details	Price	Comment
		(28 only)	*Once Daily*		

Additional Hair loss advice					
Regaine	☐	PIL given?	☐	Lifestyle advice	☐
Wigs	☐	Implants	☐	Cosmetics	☐

PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment*.

Patient Name / signature ..... **Date**.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? Yes / No

PHARMACIST AGREEMENT

I have consulted the specific PGD which enables me to supply the listed medicine and have found that the patient is included in treatment and there are no valid exclusions applicable. I have given the patient information on the risks and benefits of the medicines recommended and have done my utmost to ensure the patient fully understands them. I have also given the patient the opportunity to ask questions. This will be carried out at each appointment.

Pharmacist Name / signature ..... **Date**.....

For each follow-up consultation

New risk assessment form required after 10 consultations

Medicine Supplied	Quantity	Details	Change in medical history	Pharmacist Signature	Price
No.1			Yes ☐ No ☐		
Patient Signature			Date		
No.2			Yes ☐ No ☐		
Patient Signature			Date		
No.3			Yes ☐ No ☐		
Patient Signature			Date		
No.4			Yes ☐ No ☐		
Patient Signature			Date		
No.5			Yes ☐ No ☐		
Patient Signature			Date		
No.6			Yes ☐ No ☐		
Patient Signature			Date		
No.7			Yes ☐ No ☐		
Patient Signature			Date		
No.8			Yes ☐ No ☐		
Patient Signature			Date		
No.9			Yes ☐ No ☐		
Patient Signature			Date		
No.10			Yes ☐ No ☐		
Patient Signature			Date		