# Weight Management | 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: ◻<br>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? | ☐ | ☐ | |
| Have you had a serious reaction to orlistat before? | ☐ | ☐ | |
| Have you received advice from a weight management counsellor before? | ☐ | ☐ | |
| Are you on any medicines? Including other anti-obesity drugs? Or ciclosporin, acarbose, oral anticoagulants, levothyroxine, oral contraceptives, fat-soluble vitamins, amiodarone or any anti-epileptic drugs? | ☐ | ☐ | |
| Do you have a medical history of any of the following: chronic malabsorption syndrome, cholestasis, hepatic or renal dysfunction? | ☐ | ☐ | |
| **Current Health** | | | |
| ***Tick which of the following applies to you…*** | ***Yes*** | ***No*** | ***Details (reconfirm each appointment)*** |
| Would you object to a low calorie diet as part of treatment? | ☐ | ☐ | |
| Has a low-calorie diet failed to manage your weight in the past? | ☐ | ☐ | |
| **Body Mass Index – weight in kg divided by the square of patients height** | | | |
| ***Tick which of the following applies to you…*** | ***Yes*** | ***No*** | ***Details (reconfirm each appointment)*** |
| Is your body mass index (BMI) greater or equal to 30 kg/m²? | ☐ | ☐ | |
| Do you suffer from diabetes, coronary heart disease, hypertension, sleep apnoea or hypercholesterolaemia? If so, is your BMI above 28 kg/m²? | ☐ | ☐ | |
| **WOMEN ONLY** | | | |
| ***Tick which of the following applies to you…*** | ***Yes*** | ***No*** | ***Details (reconfirm each appointment)*** |
| Are you pregnant or planning a pregnancy? | ☐ | ☐ | |
| Are you breastfeeding? | ☐ | ☐ | |

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

## For Offical Use

### Initial consultation

| Date | Qty | Details | Pharmacist | Comment | Price |
|---|---|---|---|---|---|
| | | *120mg of **orlistat** taken immediately before, during or up to 1 hour after each main meal (up to a maximum of 360mg daily)* | | | |

**Month 2 and 3 assessment follow-up...**
(Target for initial weight loss may be lower in patients with type 2 diabetes)

| Date | Qty | Details | Pharmacist | Comment | Price |
|---|---|---|---|---|---|
| | | *120mg of **orlistat** taken immediately before, during or up to 1 hour after each main meal (up to a maximum of 360mg daily)* | | | |
| | | | | | |

**Month 4 assessment follow-up...**
Continue treatment only if weight loss since the start of the treatment exceeds 5%
(Target for initial weight loss may be lower in patients with type 2 diabetes)

| Date | Qty | Details | Pharmacist | Comment | Price |
|---|---|---|---|---|---|
| | | *120mg of **orlistat** taken immediately before, during or up to 1 hour after each main meal (up to a maximum of 360mg daily)* | | | |
| | | | | | |
| | | | | | |

| **Additional Weight Management advice** | | | | | |
|---|---|---|---|---|---|
| Smoking | ☐ | PIL given? | ☐ | Lifestyle advice | ☐ |
| Diet | ☐ | Alcohol | ☐ | Excercise | ☐ |

**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**....................................