Saxenda Risk Assessment Form

Title: Mr. Mrs. Miss Ms. Other	**D.o.B.:** _ _ / _ _ / _ _	**Age:** _____
Name:	**Home Address**	
Surname:		
Email:	**Name & Address of GP** (optional)	
Telephone:	Would you like your GP to be informed of this consultation?	

Please answer the following questions

Patients current blood pressure:	Patients 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?

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.

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		☐
Healthcare Professional Name	**Signature**	

HEALTHCARE PROFESSIONAL USE ONLY			
Date	**Body Mass Index**	**Blood Pressure**	**Additional Notes**