

WEIGHT MANAGMENT initial visit

Patient Name: _____ Referring FD/Endo: _____

Reason For Referral			
Complications/Comorbidities		Data/Labs	
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Diabetes Complications: _____ <input type="checkbox"/> CVD <input type="checkbox"/> HTN <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Psychosocial (anxiety,depression) <input type="checkbox"/> Financial		<input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Chronic Pain <input type="checkbox"/> Mobility Issues <input type="checkbox"/> _____ <input type="checkbox"/> _____	
		Family MD _____ Labs: _____ <input type="checkbox"/> Previous Weight Mgmt. Attempts	
Risk Factors			
Smoking	Smoker _____ /day Non-Smoker Ex- Smoker - year quit _____		
Alcohol	Y N _____ drinks / day week		
Current Medications			
Metformin Glumetza	_____	Humalog Humalog U200	_____
Glyburide Diamicon Diamicon MR	_____	NovoRapid Apidra	_____
GlucoNorm	_____	Humulin R Toronto	_____
Avandia Actos	_____	Humulin N Novolin NPH	_____
Januvia Onglyza Traienta	_____	Lantus Levemir Touieo	_____
Victoza Byetta Saxenda	_____	Premixed	_____
Invokana Forxiga Empa	_____	Other	_____
Is patient taking diabetes medications as directed?			
Is patient on any medications that could increase their weight?			
Safety – For Diabetes Patients			
Hypoglycemia		Driving	
Is patient experiencing lows? <input type="checkbox"/> Handout reviewed and provided		Does patient drive? Y N <input type="checkbox"/> Handout reviewed and provided	
Blood Glucose Meter		Sick Day Management	
Does patient have BG meter? Y N When was their meter last replaced or tested for accuracy? Was new meter provided to patient today? Y N How often is patient testing BG? _____ /day		<input type="checkbox"/> Handout reviewed and provided	

Assessment	Notes/ Recommendations
Activity Dose the patient participate in routine activity? Y N Notes: <input type="checkbox"/> Discussed importance / benefits of activity	Reviewed: <input type="checkbox"/> Metabolism pathophysiology <input type="checkbox"/> Medication mechanisms of action <input type="checkbox"/> Carbohydrate counting <input type="checkbox"/> Handout reviewed and provided <input type="checkbox"/> Calorie Counting <input type="checkbox"/> Barriers to weight loss <input type="checkbox"/> Benefits of weight loss <input type="checkbox"/> Confidence level 1 – 10: <input type="checkbox"/> Importance level 1 – 10: <input type="checkbox"/> GLP-1 start checklist (see attached)
Diet / Stress / Other	<input type="checkbox"/> See attached Goals & Recommendations Sheet
	Monitoring/ Follow-up <input type="checkbox"/> None required Phone: <input type="checkbox"/> _____ days <input type="checkbox"/> _____ weeks Clinic: <input type="checkbox"/> _____ weeks <input type="checkbox"/> _____ months Email: <input type="checkbox"/> consent obtained <input type="checkbox"/> _____ weeks Referral to Group Classes? Y N

Educator: _____

Date: _____