

Hair Loss | PGD Risk Assessment Form

Date: __ / __ / 20__

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			
<i>Tick which of the following applies to you...</i>	Yes	No	<i>Details (reconfirm each appointment)</i>
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			
<i>Tick which of the following applies to you...</i>	Yes	No	<i>Details (reconfirm each appointment)</i>
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?			
<i>Tick which of the following applies to you...</i>	Yes	No	<i>Details (reconfirm each appointment)</i>
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...			
<i>Tick which of the following applies to you...</i>	Yes	No	<i>Details (reconfirm each appointment)</i>
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...			
<i>Tick which of the following applies to you...</i>	Yes	No	<i>Details (reconfirm each appointment)</i>
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 Official 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		