

Ongoing Check-Up

In accordance with COMA recommendations, this patient is required to have a brief check-up every four weeks while using the LighterLife Total very-low-calorie diet (VLCD). Patients have been informed and agree to pay any fee directly to you yourselves.

Completing and signing this form does not place medical responsibility for the LighterLife Total VLCD on you or your practice.

Name: _____ Date of birth: _____

Address: _____

Postcode: _____ CIF number: _____

Please detail any prescribed medication.

Prescribed medication	Purpose of medication	Dose

Has there been a significant change in medical status? Y/N Please comment:

Blood pressure / pulse

Systolic	Diastolic	Pulse

GP / nurse / pharmacist signature (delete where appropriate)

I declare the answers I have given are a true statement to the best of my knowledge.

GP/nurse/pharmacist signature: _____

Date: _____

Please authenticate with surgery stamp

For more information on the LighterLife Total VLCD, to request a clinical information brochure or to speak to a member of our clinical team, please contact us using the details below.

Patient signature

I declare the answers are a true statement and I authorise the release of this form to my LighterLife Counsellor and LighterLife Central Office.

Patient's signature: _____

Date: _____