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General Practitioner Review

Patient Name:	
Surgery / Medical Indication:	
Referring Doctor:	
Intensiv Plan:	
Initial Weight (kg)	
Initial BMI (kg/m²)	

GP Name & Clinic:	DATE:	

Blood Pressure – Sit	tting	
Blood Pressure – Sta	anding	

PRESENT SYMPTOMS REVIEW (List symptoms)

MEDICATION REVIEW (Detail dosage and any modifications)

COMMENTS (Including any modifications to diet regime prescribed above)

_____ (Patient Name) continuing the Intensiv program as planned including a Very Low Calorie meal replacement regime.

Signed: _____ Date: _____

I consent to