

Lifestyle Risk Factor Management for Adults - Record Sheet

Clinician Code						
0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

Today's Date						
0	0	0	0	20	0	0
1	1	1	1		1	1
2	2		2		2	2
3	3		3		3	3
	4		4		4	4
	5		5		5	5
	6		6		6	6
	7		7		7	7
	8		8		8	8
	9		9		9	9

Client Age Range			
<input type="radio"/> 18 - 24	<input type="radio"/> 25 - 34	<input type="radio"/> 35 - 44	<input type="radio"/> 45 - 54
<input type="radio"/> 55 - 64	<input type="radio"/> 65 - 74	<input type="radio"/> 75 - 84	<input type="radio"/> 85 +

Client Gender
<input type="radio"/> Female
<input type="radio"/> Male

Client Postcode			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

First consultation / visit for this referral Follow-up consultation / visit for this referral

Primary Reason for visit / consultation: _____

Did you plan to discuss any of these lifestyle risk factors prior to the consultation / visit Yes No

Please indicate what risk factor management you undertook, during the consultation / visit.

Risk Factor	Please fill out for all consultations				If the issue was raised, did you.				Issue addressed in previous consultation	
	Was the Issue Raised	Was the risk factor present?			Assess?	Give Verbal Advice	Give Written Advice <small>eg pamphlet?</small>	Give Referral?		None of these
Smoking	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Don't know <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nutrition Issue / Problem	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Don't know <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol problem	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Don't know <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical inactivity	<input type="radio"/>	Yes <input type="radio"/>	No <input type="radio"/>	Don't know <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Was it/would it have been appropriate to address lifestyle risk factors with this client? Yes No

If NO, why not: _____

Please complete immediately following each consultation / visit