

**APPENDIX—WEIGHT MANAGEMENT PLAN FOR ADULTS**

This plan is intended to be a flexible tool. Some parts may be completed by a practice nurse.

**Patient details**

Name.....

.....

DOB..... Sex.....

Address.....

.....

.....

.....

Suburb.....

State..... Postcode.....

Phone.....

Occupation.....

.....

Marital status.....

Dependents.....

.....

.....

.....

.....

File Number.....

Date of Assessment.....

**I. Obesity assessment**

Weight measurement can be a sensitive issue. Discuss with patient whether measurements should be taken. If so, when, and whether patient wishes to be told results of the measurement.

Height..... m

Weight..... kg

Body mass index..... kg/m<sup>2</sup>

Waist circumference..... cm

**2. Co-morbidity assessment**

(where indicated)

**Blood pressure**

(systolic)..... (diastolic).....

**Fasting plasma analysis**

Triglyceride.....

Cholesterol.....

Insulin.....

Glucose.....

Presence of *acanthosis nigricans*  Yes  No

**Liver function tests**

Details.....

.....

**Endocrinology tests**

Details.....

.....

**Orthopaedic problems**  Yes  No

Details.....

.....

**Respiratory conditions**  Yes  No

Details.....

.....

**Gastrointestinal problems**  Yes  No

Details.....

.....

**Reproductive morbidities**  Yes  No

(e.g. menstrual irregularities)

Details.....

.....

Heat intolerance  Yes  No

Details .....  
.....

Excess sweating and intertrigo  Yes  No

Details .....  
.....

Breathlessness on exertion  Yes  No

Details .....  
.....

Tiredness  Yes  No

Details .....  
.....

Musculoskeletal discomfort  Yes  No

Details .....  
.....

**3. 'Readiness to change' assessment**

a) Has the patient sought weight loss on his or her initiative?  Yes  No

.....  
.....  
.....

b) On a scale of 1-10 (10 = high), how important is it for him/her to lose weight?

.....  
.....  
.....

c) On a scale of 1-10 (10 = high), how confident is s/he that s/he can lose weight if s/he really tries?

.....  
.....  
.....

d) What stage of readiness to change is the patient at?

- pre-contemplation  action
- contemplation  maintenance
- decision  transformation

e) How much weight does the patient expect to lose? What other benefits does s/he anticipate?

.....  
.....  
.....

**4. Risk factor assessment**

Weight history of parents and siblings

.....  
.....  
.....

Weight history of individual

.....  
.....  
.....

Life stage pregnant, menopausal, ageing

.....  
.....  
.....

Life events e.g. stress, marriage, giving up sport, quitting smoking

.....  
.....  
.....

Family, work and social environments

.....  
.....  
.....

**Medical conditions and treatments**  
(including dosage)

.....  
 .....  
 .....

**Ethnicity**

.....

**5. Lifestyle assessment**

Eating breakfast  Yes  No

Organised meals times  Yes  No

Always hungry  Yes  No

More than 3 snacks between meals  Yes  No

High intake of soft drinks or fruit juice  Yes  No

More than 2 hours of television viewing and other small-screen entertainment per day  Yes  No

Eating in front of TV  Yes  No

Is food used as a reward?  Yes  No

Is food used as a comfort?  Yes  No

Smoker  Yes  No

**a) Type of work, degree of activity**

.....  
 .....

**b) Current physical activity**

.....  
 .....  
 .....

**c) Smoking history**

Current  Yes  No

No. per day .....

Ex-smoker  Yes  No

Time quit .....

**d) Type of food eaten at meals, between meals**

Breakfast.....

.....

Lunch.....

.....

Dinner.....

.....

Snacks.....

.....

**6. Level of intervention**

**Assessment of main causes of overweight:**  
(comment on one or more)

a) Diet.....

.....

b) Physical activity.....

.....

c) Stress.....

.....

d) Psychological issues.....

.....

e) Other.....

.....

.....

Recommend diet diary?

Yes  No  Not at this satge

Recommend pedometer?

Yes  No  Not at this satge

Is specialist assessment required?

Yes  No  Not at this satge

Referral to.....

.....  
.....

**7. Management strategy**

Was advice given to:

Reduce dietary energy intake  Yes  No

Details .....

.....  
.....  
.....

Increase planned and lifestyle activity  Yes  No

Details .....

.....  
.....  
.....

Decrease sedentary behaviour  Yes  No

Details .....

.....  
.....  
.....

Modify behaviour and habits associated with eating and activity  Yes  No

Details .....

.....  
.....  
.....

**8. Goals**

a) Short term

.....  
.....  
.....  
.....

a) Long term

.....  
.....  
.....  
.....

**9. Care team**

Name.....

Contact details.....

Speciality.....

Name.....

Contact details.....

Speciality.....

Name.....

Contact details.....

Speciality.....

Referral:  Yes  No

Name.....

.....

**10. Review**

Review date.....

Agreed to.....

(Patient's Signature)