pharmadoctor

Otomize Ear Spray
Risk Assessment Form

Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Other: ☐	D.o.B.: __ / __ / __	Age: ________
Name:	**Home Address:**	
Surname:		
Email:	**Name & Address of GP** (optional)	
Telephone:	Would you like your GP to be informed of this consultation? Yes ☐ No ☐	

Please answer the following questions (must be completed by parent or guardian if under 16)

Do you currently have an infection of the outer ear?	Yes ☐ No ☐	Are you breast feeding?	Yes ☐ No ☐
Have you had a serious reaction or intolerable side effects to neomycin sulfate, dexamethasone, glacial acetic acid or any medications before? *If yes, please describe the product and the reaction*	No ☐	Do you have a perforated ear drum or grommet fitted in the affected ear?	Yes ☐ No ☐
Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant?	Yes ☐ No ☐	Do you have diabetes?	Yes ☐ No ☐
Do you have any liver or kidney problems? *If yes, please provide details*	Yes ☐ No ☐	Are you immunosuppressed due to disease or treatment?	Yes ☐ No ☐
Do you have any allergies? *If yes, please provide details*	Yes ☐ No ☐	Are you suffering from severe pain or discomfort?	Yes ☐ No ☐
Do you have an infection anywhere other than in the ear?	Yes ☐ No ☐	Do you have any open wounds or damaged skin in the affected ear?	Yes ☐ No ☐
Have you experienced a considerable amount of discharge from your ear or swelling of the ear canal?	Yes ☐ No ☐	Have you had persistent infection for the last 3 months?	Yes ☐ No ☐

Please list all symptoms you are experiencing below

Please list all your current prescription medication including any medication you buy over the counter

Please provide details of any recent or past medical history of note (e.g. other conditions you have been treated for)

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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.

Signature of patient, parent or guardian ____________________________________ **Date** ______________________________________

HEALTHCARE PROFESSIONAL USE ONLY		
Assessment	**Details**	**Date**
Diagnosis		
Further information that may be relevant (e.g. patient temperature)		

HEALTHCARE PROFESSIONAL USE ONLY	
Non-supply/administration	
I confirm that the patient did NOT receive the medication ☐	**Patient referred to GP** ☐
Reason for non-supply/administration	

HEALTHCARE PROFESSIONAL USE ONLY			
Supply/administration			
Drug brand, batch number and expiry date	Quantity	Price	Date
I confirm that the patient is not contraindicated based on the information provided by the PGD ☐			
I confirm that an ear examination has been performed to confirm the diagnosis of otitis externa ☐			
I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur ☐			
I have provided the patient with an information leaflet (PIL) for the treatment I am administering, and advised them to read it ☐			
Healthcare Professional Name			**Signature**