pharmadoctor

Norethisterone for period delay
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

Question	Answer	Question	Answer
Are you pregnant, planning pregnancy or is there any possibility that you could be pregnant?	Yes ☐ No ☐	Do you suffer from severe pruritus (itchy skin all over the body)?	Yes ☐ No ☐
Are you breast-feeding?	Yes ☐ No ☐	Do you have porphyria or jaundice?	Yes ☐ No ☐
Are you allergic to norethisterone or any other similar hormone medicines? *If yes, please provide details*	Yes ☐ No ☐	Have you previously had severe pruritus or pemphigoid gestationis (an itchy rash) during pregnancy?	Yes ☐ No ☐
Do you or your family have any current or previous bleeding disorders? *This includes (but is not limited to):* - Deep vein thrombosis (DVT) - Pulmonary embolism	Yes ☐ No ☐	Are you currently using any contraception? *If yes, please provide details*	Yes ☐ No ☐
Have you ever suffered from vaginal bleeding in which no cause was found?	Yes ☐ No ☐	Do you have any eye problems? *This includes:* - Papilloedema - Retinal vascular lesions	Yes ☐ No ☐
Do you have any liver problems? *If yes, please provide details*	Yes ☐ No ☐	Do you have any kidney problems? *If yes, please provide details*	Yes ☐ No ☐
Do you have any heart problems? *This includes (but is not limited to):* - Angina - Heart attack	Yes ☐ No ☐	Do you have any of the following: - Migraines - Epilepsy - Asthma	Yes ☐ No ☐
Do you have high cholesterol, or do you smoke?	Yes ☐ No ☐	Do you or your close family have any of the following: - Systemic lupus erythematosus - Severe obesity (BMI >30 kg/m^2) - Thromboembolism - Recurrent miscarriage	Yes ☐ No ☐
Have you previously suffered from jaundice, chloasma or pre-eclamptic toxaemia (high blood pressure) during pregnancy?	Yes ☐ No ☐	Are you being treated with steroid hormones?	Yes ☐ No ☐
Have you recently undergone major surgery or major trauma?	Yes ☐ No ☐	Have you been immobile for a prolonged time (bed rest) or are you due to receive surgery? *If yes, please provide details*	Yes ☐ No ☐
Do you have endometrial hyperplasia (thickening of uterus lining)?	Yes ☐ No ☐	Do you have any allergies? *If yes, please provide details*	Yes ☐ No ☐
Have you been told by your doctor you have an intolerance to any sugars? *If yes, please provide details*	Yes ☐ No ☐	Do you have diabetes? *If yes, please list any associated problems*	Yes ☐ No ☐

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Please answer the following questions			
Do you have a known or suspected cancer, or have you had cancer in the past (e.g. breast cancer)? *If yes, please provide details*	Yes ☐ No ☐	Do you have severe depression, generalized anxiety disorder or any other psychiatric disorder?	Yes ☐ No ☐
Have you previously had a transient ischaemic attack (mini stroke) or stroke?	Yes ☐ No ☐	Do you have inflammation of your veins (superficial phlebitis) or varicose veins?	Yes ☐ No ☐
Why do you want to delay your period?			
Please provide details of any recent or past medical history of note (e.g. other medical conditions that you have previously been treated for)			
Please list all your current medication including any prescribed and any medication you buy over the counter (including enzyme inducers)			

Patient consent	
I have received information on the risks and benefits of the treatment and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the treatment being given.	
Signature of patient	
Date	_ _ / _ _ / _ _ _ _

HEALTHCARE PROFESSIONAL USE ONLY		
Assessment	**Details**	**Date**
Blood pressure		
Further information that may be relevant		

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	*Affix label here or write details*	Date	Cost
I confirm that the patient is not contraindicated based on the information provided by the PGD			☐
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 supplying, and advised them to read it			☐
Healthcare Professional Name		**Healthcare Professional Signature**	