pharmadoctor

Nitrofurantoin
Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ 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

Do you have any allergies? Yes ☐ No ☐ *If yes, please describe the allergy/reaction*	Do you have any bladder problems? Yes ☐ No ☐ *If yes, please provide details*
Have you ever had an allergic or anaphylactic reaction to nitrofurantoin or any other antibiotics? Yes ☐ No ☐ *If yes, please provide details*	Do you have any liver problems? Yes ☐ No ☐ *If yes, please provide details*
Are you still experiencing symptoms from a previous urinary tract infection? Yes ☐ No ☐	Do you have any of the following? Yes ☐ No ☐ - G6PD deficiency - Porphyria (blood disorder) - Anaemia - Diabetes mellitus - Electrolyte imbalance - Debilitating conditions - Peripheral neuropathy (including those susceptible to peripheral neuropathy) - Pulmonary disease - Vitamin B deficiency (particularly folate deficiency). - Neurological disorders - Allergic diathesis
Are you pregnant, planning pregnancy or is there a possibility you may be pregnant? Yes ☐ No ☐	Are you currently breast-feeding? Yes ☐ No ☐
Are you using an indwelling urinary catheter? Yes ☐ No ☐	Are you due to receive vaccination with the oral typhoid vaccine (Vivotif)? Yes ☐ No ☐
Have you been told by your doctor that you have an intolerance to any sugars (e.g. galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption)? Yes ☐ No ☐ *If yes, please provide details*	Are you familiar with the symptoms of an uncomplicated lower urinary tract infection (UTI)? Yes ☐ No ☐
Are you immunosuppressed through disease, treatment or medication? Yes ☐ No ☐	Do you suffer from recurring urinary tract infections? Yes ☐ No ☐
Do you have any kidney problems? Yes ☐ No ☐ *If yes, please provide details*	Do you have a history of upper urinary tract infection (affecting the kidneys)? Yes ☐ No ☐ *Ask your healthcare professional if you are unsure*

Have you suffered from more than 3 episodes of UTI in the past 12 months, or more than 2 episodes in the past 6 months? Yes ☐ No ☐

If yes, was this investigated by your GP or other specialist? Yes ☐ No ☐
If yes, please provide details of the outcome

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Please answer the following questions			
Have you previously sought advice from your GP about an uncomplicated lower urinary tract infection (UTI)?	Yes ☐ No ☐		
Have you suffered from a UTI in the past 3 months?	Yes ☐ No ☐		
Have you ever experienced the symptoms below with a urinary tract infection (UTI)?	Yes ☐ No ☐		
Blood in your urine	☐	Flank pain or loin pain	☐
Nausea or vomiting	☐	Altered mental state	☐
Kidney pain/tenderness in back under ribs	☐	New/different muscle pain	☐
Fever or rigors (cold feeling with shivering)	☐	Other severe symptoms	☐
Details:			
If yes to the above question, were your symptoms investigated by your GP or other specialist? *If yes, please provide details of the outcome*	Yes ☐ No ☐		
Do you require a supply of stand by treatment for a urinary tract infection? *If yes, please provide a reason below*	Yes ☐ No ☐		
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. conditions you have previously been treated for)			

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. Furthermore, I am aware of when treatment can be initiated and will contact my GP or local NHS services (111) before taking the initial dose if symptoms are not typical of a lower urinary tract infection.

Signature of patient _____ **Date** _____

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	
Supply/administration	
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	☐
I have advised the patient when treatment can be initiated and when to contact their GP or local NHS services (111) before taking their initial dose	☐
Healthcare Professional Name	**Healthcare Professional Signature**