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 or kidney problems? Yes ☐ No ☐ *If yes, please provide details*
Do you have any symptoms? Yes ☐ No ☐ *If yes, please provide details*	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 ☐
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 receiving vaccination with the oral typhoid vaccine (Vivotif) or have you completed vaccination in the last 10 days? Yes ☐ No ☐
Are you using an indwelling urinary catheter? Yes ☐ No ☐	Are you suffering from any of the following symptoms? Yes ☐ No ☐ - Flank pain - Loin pain - Fever - Kidney pain/tenderness in back under ribs - New/different muscle pain - Flu like illness - Shaking chills (rigors) - Nausea/vomiting
Have you been treated for a urinary tract infection in the last 3 months? Yes ☐ No ☐	Do you suffer from recurring urinary tract infections? Yes ☐ No ☐
Are you immunosuppressed through disease, treatment or medication? Yes ☐ No ☐	Do you have blood in your urine? Yes ☐ No ☐

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Please answer the following questions
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)

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**
Diagnostic test kit result (s)		
Patient temperature		
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		
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		☐
Healthcare Professional Name	**Healthcare Professional Signature**	