**Oral/PATCH/RING Contraceptive**

**repeat prescription request**

Please complete this form if you require a repeat prescription of your contraceptive and allow 3 working days for your prescription to be available.

Unless there are any medical contraindications, you will be issued with a 12 month supply of medication.

Please delete as applicable collect / delivered to pharmacy......................................

If we are unable to issue your prescription, you will be asked to make an appointment with a GP or nurse to discuss your contraceptive needs.

**Full Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth**

**Full Address**

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**Contact telephone Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently using the oral contraceptive pill, patch or ring?**

Yes ○ No ○ (If the answer is no, please book a GP appointment)

**What is the name of the contraceptive you are using?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you noticed any side effects?**

Yes ○ (please describe) No ○ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have you forgotten to take your pill more than once in the last 6 months?**

Yes ○ No ○

**Are you currently taking any medication (including herbal remedies) or have you recently finished a course of any medication?**

Yes ○ (please list) No ○

**Do you have any drug allergies?**

Yes ○ (please list) No ○

**Do you ever get severe headaches or migraines?**

Yes ○ No ○

**If yes, do you get any visual disturbances/flashing lights?**

Yes ○ No ○

**Have you ever had a heart problem, stroke, or high cholesterol?**

Yes ○ No ○

**Have you ever had problems with your kidneys or liver?**

Yes ○ No ○

**Do you have any complications from diabetes (e.g. with your eyes, kidneys or sensation in your hands/feet)?**

Yes ○ No ○

**Have you ever had any form of cancer?**

Yes ○ No ○

**Have you or anyone in your family ever had blood clots (e.g. DVT or PE) or a clotting disorder?**

Yes ○ No ○

**Are you known to be a carrier of the BRACA gene or have any undiagnosed breast lumps?**

Yes ○ No ○

**Have you ever suffered from high blood pressure, including during a pregnancy?**

Yes ○ No ○

**Are you pregnant or trying to become pregnant?**

Yes ○ No ○

**Have you given birth in the last 6 weeks?**

Yes ○ No ○

**Are you currently breastfeeding?**

Yes ○ (please state how long for) No ○

**Do you have any other health conditions or symptoms (including recent surgery)?**

Yes ○ (please describe) No ○

**If yes to any of the previous questions, please provide further information**

**Do you smoke?**

Yes **○ \_\_\_\_\_\_\_\_\_\_\_\_** per week No ○

**How many units of alcohol do you consume per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your height (in cm)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your weight (in kg)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had a blood pressure check in the last 12 months?**

Yes ○ (please provide latest reading) No ○ (see below)

BP reading \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date taken \_\_\_\_\_\_\_\_\_\_\_\_

**We are unable to issue the medication without an up to date blood pressure, height and weight. Home readings are acceptable, or you can make an appointment with the healthcare assistant at the surgery or your local pharmacy.**

Would you be interested in considering long acting contraception, such as an implant, coil or injection?

Yes ○ (please make a GP appointment to discuss this) No ○

**Contraceptive pills prevent pregnancy but not sexually transmitted infections. If you think you may be at risk of sexually transmitted infection, please make an appointment with a local sexual health clinic or a GP.**

Further information about contraception can be viewed online at [www.fpa.org.uk](http://www.fpa.org.uk) (The Family Planning Association).

Any other comments

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**For Office Use Only**

**Outcome**:

Outcome

Prescription issued for Rigevidon ○

 Loestrin 20 ○

Loestrin 30 ○

 Cilique ○

Cerelle ○

 Noriday ○

Evra ○

 Nuvaring ○

Date issued\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issued by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Unable to issue prescription due to :

Contraindication ○

Unable to issue prescription due to:

Drug interaction ○

Request for contraceptive not listed above ○

Other ○

Please explain

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**Please complete the contraception template on EMIS and scan the completed form to Docman. If unable to issue a prescription please pass to reception to be added onto GP acute prescription list.**

GP comments

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