pharmadoctor

Candidal skin infection 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

Do you suffer from severe or recurrent infection? Yes ☐ No ☐	Have you had a serious reaction or intolerable side effects to clotrimazole (Canesten), miconazole nitrate, hydrocortisone or any other medications before? Yes ☐ No ☐ *If yes, please describe the product and the reaction*
Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant? Yes ☐ No ☐	Are you breast feeding? Yes ☐ No ☐
Do you have infection of the nails, scalp or genitals? Yes ☐ No ☐ *If yes, please provide details*	Do you have any allergies? Yes ☐ No ☐ *If yes, please provide details*
Are you immunosuppressed through disease or treatment? Yes ☐ No ☐ *If yes, please provide details*	Do you have any other skin problems? Yes ☐ No ☐ *Please provide details*
Do you have diabetes? Yes ☐ No ☐	Have you received treatment for candidal skin infection previously? Yes ☐ No ☐ *If yes, please provide treatment date* If yes, was the treatment effective? Yes ☐ No ☐
Do you have anaemia? Yes ☐ No ☐	Are the infected areas itchy or inflamed? Yes ☐ No ☐

Please list any symptoms that 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

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** _____

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HEALTHCARE PROFESSIONAL USE ONLY		
Assessment	**Details**	**Date**
Diagnosis		
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