pharmadoctor

Oral Contraceptives Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ☐	**D.o.B.:** _ _ / _ _ / _ _	**Age:** _____
Name:	**Home Address:**	
Surname:		
Email:	**Name & Address of GP**	
Telephone:		

Please answer the following questions

Do you have any recent or past medical history of note? Yes ☐ No ☐ *If yes, please provide details*	Is the contraceptive for your own use? Yes ☐ No ☐
Do you take any current or repeat medicines? Yes ☐ No ☐ *If yes, please provide details*	Is there a possibility you may be pregnant? Yes ☐ No ☐
Are you over 35 years of age and a smoker? Yes ☐ No ☐	Are you overweight? Or have blood pressure problems? Yes ☐ No ☐ *If yes, please provide details below (if you are unsure, your healthcare professional can check this for you)*
Do you have a family history of blood clots or thrombosis? Yes ☐ No ☐ *If yes, please provide details*	Do you have any of the following conditions? Diabetes, migraine headaches, cancer, HIV, high blood pressure, liver disease? Yes ☐ No ☐ *If yes, please provide details*
Have you been taking your current contraceptive pill for more than a year? Yes ☐ No ☐	Have you been prescribed the same contraceptive pill for more than 9 months? Yes ☐ No ☐
Have you had a check up with your doctor / nurse about your contraceptive pill in the last year? *If yes, please provide details*	Are you having any problems with your current contraceptive pill such as irregular bleeding / periods? *If yes, please provide details*
Please write below any further information which may be relevant e.g. medicines, conditions...	

Confidential sexual health patient helplines

FPA (formerly the Family Planning Association) national helpline – 0845 3101334

Sexual Health Line – 0800 567 123

Brook Clinic – 0800 0815023 or www.brook.org.uk

Sexwise – 0800 282930 or http://www.maketherightdecision.co.uk

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Oral Contraceptives Risk Assessment Form

FOR OFFICIAL USE- HEALTHCARE PROFESSIONAL USE ONLY

Retain completed forms for 8 years. Fax or post copy of completed form to GP within 3 months

This form is intended to be used per supply. For additional supplies to the same patient, a new form will be needed.

Product: (e.g. Microgynon)

Date	Quantity*	Referral required?	Directions	Pharmacist	Signature
		Yes ☐ No ☐ If yes, see below.	Take once daily.		

Reason for referral

*** Maximum of one issue of 3 calendar-packs in each 9 month period.**

Missed pill advice

Combined oral contraceptive pills (21 active tablets)

Take the missed pill as soon as you remember then continue as normal, with extra precautions (barrier methods) required for 7 days. These rules are applicable no matter where in the packet the patient is.

Progestogen-only pills

The missed pill should be taken as soon as remembered. If more than one pill has been missed, only one pill should be taken. The next pill should be taken at the usual time. This may mean that two pills are taken in 1 day. Additional contraceptive precautions (condoms or avoidance of sex) are advised for 2 days (48 hours) after restarting the POP.

The patient information leaflet that comes with the pill might say to use condoms for the next seven days after remembering to take the pill. This is because it takes seven days for the pill to suppress ovulation.

If the patient has had UPSI and missed pills then consider EC (as per emergency contraception PGD) do not supply COCs/POPs to patients with suspected pregnancy.

Additional advice

STIs ☐	Barrier Contraceptives ☐	Sexual Health Helplines ☐	Efficacy ☐	LARCs (IUD, IUS, or Implanon) ☐	Cervical screening ☐

Record of supply

Drug brand, batch number and expiry date.	Date	Qty	Details	Price	Comment

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 administering, and advised them to read it	☐

PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment.

Patient signature_____ **Date** _____

Healthcare professional signature _____ **Date** _____