The Wellbridge Practice - HRT request form

Date received: ………………….

Date dealt with: ……………….

GP initials: ………………………..

This form is for tablet/patch/topical requests, you do not need to use this form for pessaries

or gel which is applied intra-vaginally, these can be requested via your repeat medication list

**PLEASE COMPLETE ALL QUESTIONS**

**INCOMPLETE FORMS WILL NOT BE PROCESSED**

|  |  |  |  |
| --- | --- | --- | --- |
| Full name |  | Date of birth |  |
| Contact number |  | Consent to TEXT | **YES/NO** |
| Are you less than 60 years old? | **YES/NO** |
| Do you wish to continue your HRT preparation unchanged? | **YES/NO** |
| **If the answer to either of the above is NO please make an appointment to speak to a clinician.** |
| What is the **brand** name of your HRT? |
| How long do you have left on your current prescription?**We recommend you make this request when you have one month left from your previous prescription. More urgent requests should also be completed on this form but we cannot guarantee a quick turnaround** |

**Please take two blood pressure readings at least 5 minutes apart (mandatory information):**

|  |  |
| --- | --- |
|  Date | BP Reading (e.g. 120/80) |
| 1. |  |  |
| 2. |  |  |

**Please provide your current height and weight in kg / cm (mandatory information):**

|  |  |  |  |
| --- | --- | --- | --- |
| Weight\* |  **kg** | Height |  **cm** |

**Please record your smoking status and alcohol intake (mandatory information):**

|  |  |  |  |
| --- | --- | --- | --- |
| Never smoked |  | Ex-smoker |  |
| Smoker\* |  | What + how much? |  |
| Alcohol units per week\* |  |  |  |

|  |  |  |
| --- | --- | --- |
| 1 | Have you had a hysterectomy? (if YES please skip to Q8) | **YES/NO** |
| 2 | Are your cervical smears up to date?**If not please book an appointment with the practice nurse. Please note you would normally receive a letter if your cervical smears are not up to date.** | **YES/NO**  |
| 3 | Do you have periods on your HRT? | **YES/NO** |
| 4 | If yes are they regular? | **YES/NO** |
| 5 | Do you have any concerns about your bleeding pattern? | **YES/NO** |
| 6 | Do you require regular contraception? | **YES/NO** |
| 7 | Do you have a Mirena coil fitted? | **YES/NO** |
| 8 | Are you regularly self-examining your breasts? | **YES /NO** |
| 9 | Do you have any concerns about your breasts? | **YES /NO** |
| 10 | Have you had a mammogram? (age 50-71, 3 yearly) If so when was your last mammogram and what was the result? **DATE: RESULT:**resuresult? **YES/NO**If so when was your last mammogram and what was the result? | **YES/NO** |
| 11 | Have you considered reducing or stopping your HRT? | **YES/NO** |
| 12 | Do you have any concerns about your HRT? | **YES/NO** |

Please read (and keep) the attached HRT information sheet before you proceed, you can use the link below to read it electronically <https://assets.publishing.service.gov.uk/media/5d68d0e340f0b607c6dcb697/HRT-patient-sheet-3008.pdf>

\*If you are interested in support to help you to lose weight, stop smoking or reduce your alcohol intake please see [www.livewelldorset.co.uk](http://www.livewelldorset.co.uk) or call 0800 840 1628 for information.