WELLINGTON
Medical Practice

Oral contraceptive pill request form

Please complete this form to request a repeat prescription of your oral contraceptive pill
A doctor may need to speak to you prior to issuing the prescription.
Please book a telephone appointment if you are requesting a new medication or a contraception clinic appointment if you are experiencing any side-effects or problems with contraception
Information on different contraceptive methods is available via our website www.wellingtonmedicalpractice.co.uk

Name: ……

Date of Birth: ……

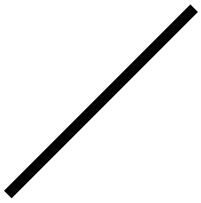
Contact phone number ……

Name of pill requested Microgynon ❑ Cerazette ❑

Other :……

Please provide a blood pressure (BP) reading taken within the previous month.
You can check your BP in the Health Hub area of the waiting room or book an appointment with the healthcare assistant/Practice Nurse

WRITE YOUR BP HERE



What is your weight? (kg) kg

What is your height? (cm) cm

Have you had a baby in the previous 6 weeks?
No ❑ Yes ❑

Do you smoke OR have you stopped smoking within the previous 12 months?*
No ❑ Yes ❑

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Have you ever had breast cancer OR do you have any undiagnosed breast symptoms OR are you known to have any breast gene mutation (e.g. BRCA1)?
No ❑ Yes ❑

Have you ever had a blood clot in your legs or lungs (deep vein thrombosis or pulmonary embolism) OR are you known to have a blood clotting mutation?
No ❑ Yes ❑

Have you ever been diagnosed with diabetes, high blood pressure, heart problems, stroke or high cholesterol?
No ❑ Yes ❑

Have you ever been diagnosed with a liver or gallbladder problem?
No ❑ Yes ❑

Have you ever been diagnosed with systemic lupus erythematosis (SLE) or with antiphospholipid antibodies?
No ❑ Yes ❑

Have you ever had a headache or migraine associated with visual disturbance, flashing lights, loss of vision, temporary numbness, paralysis or difficulty with speech?
No ❑ Yes ❑

Are you due to have any major surgery or have you had any major surgery in the previous 3 months?
No ❑ Yes ❑

Have any of your first-degree relatives had a blood clot in the legs or lungs (deep vein thrombosis or pulmonary embolism)?
No ❑ Yes ❑

Are you taking any prescribed or over-the counter medication?
No ❑ Yes ❑

I confirm that this is a repeat prescription request
No ❑ Yes ❑

❑ I confirm the above information is accurate and up to date.
❑ I confirm that any medication prescribed for me is for my personal use only and that I have read the appropriate information leaflet on my chosen contraception pill - which can be accessed at www.wellingtonmedicalpractice.co.uk and I am aware of how to take my chosen pill and what to do if I miss a pill.

Patient Signature…….. date …….

GP/ANP ACTION
❑ Able to prescribe - Prescription generated
❑ Unable to prescribe - Please book contraception clinic appt
Signature …….. date …….