|  |
| --- |
| **HRT – RENEWAL FORM** |
| **Name**  |  |
| **Date of birth & age** |  |
| **Phone Number** |  |
| **Length of time HRT** **Name of HRT**  |  |
| **Have you had hysterectomy?** |  |
| **Have you ever been diagnosed with endometriosis?**  |  |
| **What form of HRT do you use** **Tablets, gel, patches?** |  |
| **Have you got a coil and if so what type of coil and when was this inserted?** |  |
| **Do you have any bleeding on HRT? If so how often?** |  |
| **Do you smoke? If so, how many cigarettes or roll-ups a day?** |  |
| **HRT is not a contraception.****Are you using any contraception if < 55yrs old**  |  |
| **Do you have any bleeding after sex?**  |  |
| **Do you have any breast disease (e.g. breast cancer) in your family?**  |  |
| **Have you ever had breast disease (eg breast cancer)?** |  |
| **Has anyone in your family suffered from a blood clot (stroke or DVT)?**  |  |
| **Have you ever suffered from a blood clot (stroke or DVT)?** |  |
| **Any new problems on the HRT, or changes since you had your last HRT check?** **Please describe** |  |
| **Are you up to date with smear?****When was your last smear?** |  |
| **Do you have any other health problems in particular heart problems or stroke?** |  |
| **Your recent blood pressure reading ?** **This can be done at a pharmacy or with a home machine.** **WE CANNOT ISSUE A NEW SUPPLY OF HRT WITHOUT THIS** |  |
| **What is your weight and height?****MANDATORY MUST BE COMPLETED**  |  |
| **Would you be happy to try to stop HRT or gradually wean off?** |  |
| **Clinician Use ONLY** *Check the accuracy of the prescription you are issuing against the HRT renewal form as well as all previously issued prescriptions for HRT.**Please ensure that entry is coded with: USE AUTOCONSULTATION*Read codeY1f3b , econsultation via online application. Date  |  |

Email completed form back to hhcdata.almondroadsurgery@nhs.net

Or hand in at reception.