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| **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](mailto:hhcdata.almondroadsurgery@nhs.net)

Or hand in at reception.