URINE SAMPLING

Name: _____Date of Birth: _____

Contact Number: _____

Have you contacted the surgery and been asked to bring in a urine sample? (Please tick as appropriate)

YES I have symptoms - ☐

I have been asked to bring this in ☐

NO ☐

If you have not been contacted to provide a sample, please fill out the following as completely as possible:

What are your symptoms?	
How many days have you been having these symptoms?	
Do you have a fever and or shivering?	
Are you pregnant?	
Do you have any medication allergies?	
Have you had these symptoms or been prescribed antibiotics before?	

Please ensure you are available to be contacted by the practice team.