

Contraceptive Pill Repeat Prescription Request Form

You may apply for a repeat prescription of the same contraceptive pill if:

- you are aged between 18 and 35
- you are currently taking one of the following contraceptive pills that has been prescribed by a GP at our practice

PLEASE TICK THE PILL YOU ARE TAKING

Combination pills

- | | | | |
|--------------------------------------|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> BREVINOR | <input type="checkbox"/> LOESTRIN | <input type="checkbox"/> MINULET | <input type="checkbox"/> TRINORDIOL |
| <input type="checkbox"/> CILEST | <input type="checkbox"/> LOGYNON | <input type="checkbox"/> NORIMIN | <input type="checkbox"/> TRINOVUM |
| <input type="checkbox"/> FEMODENE | <input type="checkbox"/> MARVELON | <input type="checkbox"/> OVRANETTE | <input type="checkbox"/> FEMODETTE |
| <input type="checkbox"/> MERCILON | <input type="checkbox"/> TRIADENE | <input type="checkbox"/> FEMULEN | <input type="checkbox"/> MICROGYNON |
| <input type="checkbox"/> TRI-MINULET | | | |

Progestogen-only pills

- | | | |
|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> MICRONOR | <input type="checkbox"/> MICROVAL | <input type="checkbox"/> NORIDAY |
|-----------------------------------|-----------------------------------|----------------------------------|

For your safety, to apply for a repeat prescription:

You must have had your blood pressure and weight measured in the last year, either in the Practice or by a health professional.

- If your blood pressure and weight have been measured elsewhere, please enclose a signed note from the person taking the readings, with details
- If your blood pressure and weight have not been measured at all, please make an appointment for a blood pressure and weight check with the clinical support team at the practice
- We will also need a record of your height within the last 5 years
- If your weight or blood pressure are outside certain limits you will need to see a nurse

You must have had a cervical smear test within the last three years if you are aged 25 or over.

If you have

- Any problems with your general health
- Any problems with using your contraceptive pill or side effects from the pill
- Any health matters you wish to discuss with your GP or practice sister

then please do not use the form, but make an appointment to see the practice sister.

Please allow two working days for your repeat prescription to be ready. If you wish to have your prescription posted to you, please enclose a stamped addressed envelope.

Please note that no prescription will be issued unless all questions on the form have been answered and all the requirements above have been met.

How to use the form:

Please answer all the questions by ticking the relevant box, sign the signature box **and hand the form in at reception to be checked**. Alternatively you can send the form to Contraception Repeats, Ashley Medical Practice 1a Crutchfield Lane Walton-on-Thames Surrey KT12 2QY. Enclose a stamped addressed envelope if you wish your prescription to be posted to you. Please allow two working days for your repeat prescription to be ready. Please be aware that if your completed form is not checked by the reception team we may require you to come to the surgery for various checks, resulting in a delay to your prescription.

Contraceptive Pill Repeat Prescription Request Form

Do you have:	Yes	No
Any problems with your general health	<input type="checkbox"/>	<input type="checkbox"/>
Any problems with using your contraceptive pill or side effects from the pill	<input type="checkbox"/>	<input type="checkbox"/>
Any health matters you wish to discuss with your GP or Practice Sister	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches, severe headaches or frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding during or after sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Unusual discharge	<input type="checkbox"/>	<input type="checkbox"/>
Depression or depressed mood	<input type="checkbox"/>	<input type="checkbox"/>
History of thrombosis (blood clots in veins or lungs)	<input type="checkbox"/>	<input type="checkbox"/>

If the answer to any of the questions is YES please make an appointment with the Practice Sister.

Have you received the family planning association leaflet concerning your contraceptive pill? (If **No** we will enclose one with your prescription)

Yes **No**

I have had my blood pressure and weight checked in the past year

at the Practice

by another health care professional (details enclosed)

If you have not had your height measured in the last 5 years please give your height: _____

Declaration

I understand that the contraceptive pill has certain risks attached to it as outlined in the patient leaflet previously provided with my pills and that smoking increases these risks.

Name (block capitals and black ink please)	Date of Birth
Address	
Signature	Today's Date

Please hand the form in at reception to be checked. Alternatively you may send it to: Contraceptive Repeats, Ashley Medical Practice 1a Crutchfield Lane Walton-on-Thames Surrey KT12 2QY. Enclose a stamped addressed envelope if you wish your prescription to be posted to you. However, please be aware that if your completed form is not checked by the reception team we may require you to come to the surgery for various checks, resulting in a delay to your prescription.

Practice Use Only

	Value	Date	Initials
Age Checked			
BMI (if over 30 must see nurse)			
BP (if top no over 140 OR bottom no over 90 must see nurse)			
Smear (age 25+)			

Prescription issued for 6/12 – Pills issued: 126 182 FPA leaflet enclosed Yes No