pharmadoctor

Acetazolamide for altitude sickness
Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ☐	**D.o.B.:** __ / __ / __	**Age:** ________
Name:	**Home Address:**	
Surname:		
Email:	**Name & Address of GP** (optional)	
Telephone:	**Would you like your GP to be informed of this consultation?** Yes ☐ No ☐	

Please answer the following questions

Question		Question	
Do you have any kidney problems? *If yes, please provide details*	Yes ☐ No ☐	Do you have epilepsy?	Yes ☐ No ☐
Have you ever had an allergic or anaphylactic reaction to tablets containing sulphonamides, sulphonamide derivatives (including acetazolamide) or any other tablets? *If yes, please provide details*	Yes ☐ No ☐	Do you have any allergies? *If yes, please describe the allergy/reaction*	Yes ☐ No ☐
Have you previously had, or do you have kidney stones?	Yes ☐ No ☐	Do you have reduced function of the adrenal glands?	Yes ☐ No ☐
Do you understand that acetazolamide is not licenced for acclimatisation though it is being supplied in line with official recommendations? *Your supplier will be able to provide further details*	Yes ☐ No ☐	Do you have any problems breathing, or do you have any lung problems? *If yes, please provide details*	Yes ☐ No ☐
Do you have any of the following? - Pulmonary obstruction - Emphysema - Diabetes mellitus - Impaired alveolar ventilation	Yes ☐ No ☐	Have you been diagnosed with any of the following? - Suprarenal gland failure - Hypokalaemia - Hyponatremia, - Adrenocortical insufficiency - Addison's disease	Yes ☐ No ☐
Do you have high chlorine blood levels, or have you been diagnosed with hyperchloremic acidosis? *Your doctor will be able to advise you*	Yes ☐ No ☐	Do you have decreased sodium and/or potassium blood levels? *Your doctor will be able to advise you*	Yes ☐ No ☐
Are you pregnant, planning pregnancy or is there a possibility that you could be pregnant?	Yes ☐ No ☐	Are you breast-feeding?	Yes ☐ No ☐
Do you have any liver problems? *If yes, please provide details*	Yes ☐ No ☐	Do you have any current or previous history of depression, generalized anxiety disorder or any other psychiatric disorder? *If yes, please provide details*	Yes ☐ No ☐
Are you a frequent traveller?	Yes ☐ No ☐	Are you aware of the ways in which you can reduce the symptoms of altitude sickness?	Yes ☐ No ☐

Do you have any recent or past medical history of note? Yes ☐ No ☐
If yes, please provide details

Please list all your current prescription medication including any medication you buy over the counter

What location are you travelling to that requires altitude sickness medication?

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CONSENT

I have received information on the risks and benefits of the treatment and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the treatment being given.

Signature of patient___________________________________ **Date** ______________________________________

HEALTHCARE PROFESSIONAL USE ONLY		
Non-supply/administration		
I confirm that the patient did NOT receive the medication ☐	**Patient referred to GP** ☐	
Reason for non-supply/administration		
Supply/administration		
Drug brand, batch number and expiry date.	Date	Cost
I confirm that the patient is not contraindicated based on the information provided by the PGD ☐		
I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur ☐		
I have provided the patient with an information leaflet (PIL) for the treatment I am supplying, and advised them to read it ☐		
Healthcare Professional Name	**Healthcare Professional Signature**	