pharmadoctor

Jet lag
Risk Assessment Form

Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ 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

Do you have any allergies? *If yes, please provide details*	Yes ☐ No ☐	Have you had a serious reaction or intolerable side effects to melatonin or any other medications before? *If yes, please describe the product and the reaction*	Yes ☐ No ☐
Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant?	Yes ☐ No ☐	Are you breast feeding?	Yes ☐ No ☐
Do you have a medical history of any of the following? - Renal / kidney problems - Liver problems - Seizure disorders (e.g. epilepsy) - Neurological problems	Yes ☐ No ☐	Do you have a current or previous history of depression, suicidal thoughts, generalized anxiety disorder or any other psychiatric disorder?	Yes ☐ No ☐
Do you have any autoimmune diseases? *If yes, please provide details*	Yes ☐ No ☐	Have you been told by your doctor you have an intolerance to any sugars (e.g galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption)? *If yes, please provide details*	Yes ☐ No ☐
Do you have high blood pressure?	Yes ☐ No ☐	Do you have diabetes?	Yes ☐ No ☐
Are you a heavy smoker?	Yes ☐ No ☐	Are you a heavy drinker?	Yes ☐ No ☐

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

Please provide details of any recent or past medical history of note

Destination country	Arrival date	Departure date

PATIENT 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** ______________________________________

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HEALTHCARE PROFESSIONAL USE ONLY		
Assessment	**Details**	**Date**
Blood pressure		
Further information that may be relevant		

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**	