pharmadoctor

Hair loss (finasteride 1 mg)
Risk Assessment Form

How to use this form

To ensure the security of patient information, all consultations are to be completed in your Pharmadoctor account using the eTool, with this paper form only used to record the consultation ID (generated by the eTool at the patient consent stage) and the medical details (fields in black ink with bold borders).

Only if you do not have access to your Pharmadoctor account at the time of the consultation should the fields in grey text be filled out. You must then upload the consultation details at a later time when you have access to the Pharmadoctor eTool.

Patient details

Consultation ID	Date of birth: __ / __ / ____ Age: ________
Full name:	Home Address:
Email:	
Telephone:	Name & Address of GP
NHS number: (optional)	Would you like your GP to be informed of this consultation? Yes ☐ No ☐

Please answer the following questions

Do you have any recent or past medical history of note? Yes ☐ No ☐ *If yes, please provide details*	Do you have any allergies? Yes ☐ No ☐ *If yes, please provide details*
Have you had a serious reaction to any hair loss medicines before? Yes ☐ No ☐	Do you agree to tell your doctor or supplier about any side effects you may be experiencing with the medicines and any progression of symptoms? Yes ☐ No ☐
Do you suffer from any scalp conditions (such as fungal infection)? Yes ☐ No ☐	Do you understand that any hair growth may be lost 6-12 months after treatment? Yes ☐ No ☐
Have you had any rapid weight loss in the past 6 months? Yes ☐ No ☐	Is your hair loss accompanied by any red, inflamed, scaly or itchy skin? Yes ☐ No ☐
Is the progression of your hair loss symmetrical (the same on the right as on the left side of your scalp)? Yes ☐ No ☐	Do you have depression, generalized anxiety disorder, psychosis, schizophrenia, or any other psychiatric disorder? Yes ☐ No ☐
Is the hair loss only located at the temples or the side of the forehead? Yes ☐ No ☐	Do you have a history of depression, generalized anxiety disorder or any other psychiatric disorder? Yes ☐ No ☐
Is your hair loss in clumps/patches, or is the hair loss rapid? Yes ☐ No ☐	Do you suffer from bladder obstruction (obstructive uropathy)? Yes ☐ No ☐
Do you understand that regrowth of hair can take up to 6 months and is most effective up to 2 years? Yes ☐ No ☐	Do you have any liver problems (hepatic impairment)? Yes ☐ No ☐
Do you have any problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption? Yes ☐ No ☐	Are you aware that crushed or broken tablets of finasteride should not be handled by women when they are or may potentially be pregnant? Yes ☐ No ☐
Do you have any chronic medical conditions (e.g. cancer)? Yes ☐ No ☐ *If yes, please provide details*	Are you aware that you should tell your doctor you are receiving treatment before having a prostate-specific antigen (PSA) test? Yes ☐ No ☐

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

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Patient consent
1. I have received information on the risks and benefits of the medicine, 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 medicine being administered.
2. I understand that my personal information, including name, surname, email, telephone, date of birth (DOB), address, NHS number, and GP details, will be securely uploaded to the Pharmadoctor website for electronic storage, and it will be kept in line with data protection regulations along with the details of the consultation (i.e., medicines provided).
3. I authorise the collection, storage, and secure transmission of my information for the purposes mentioned above.
4. I acknowledge that after the consultation, the details of my medication and consultations will be accessible through my Pharmadoctor account, using the provided email address for login.
5. I understand that I can speak to a member of staff about any queries regarding the Pharmadoctor consultation or the processing of personal data for this consultation, including exercising my rights under data protection legislation.

Verbal consent (if used)	
I confirm that the patient, parent or guardian has given verbal consent.	☐

Written consent (if used)	
Patient signature:	**Date:**

Additional information (healthcare professional use)	
Further information that may be relevant	

Supply record (healthcare professional use)							
Medicine name	Date provided	Administration method	Quantity	Strength	Batch number	Drug expiry date	Price
Comments							
Comments							
Comments							
Comments							