SANDYLIGHT PHARMACY

Erectile Dysfunction Patient Risk Assessment and Consent Form

Date:

Patient's personal details	
Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Dr: ☐	Patient Address:
First Name:	NHS No. (if known):
Last Name:	GP Name and Address:
Telephone:	GP Telephone (if known):
Gender: **Male**. D.O.B:_____ AGE:	Would you like us to send a copy of this consultation to your GP? ☐

Patient's personal details			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Do you have any recent or past medical history of note?			
Do you take any current or repeat medicines?			
Do you have higher or lower than normal blood pressure?			
Have you had a serious reaction to an ED medicine before?			
Do you have a medical history of the following: heart disease, heart attack, angina (chest pain during exertion), stroke, mini-stroke (transient ischaemic attack), sight loss due to poor circulation, inherited eye disease – retinitis pigmentosa, severe kidney or liver disease, deformity of the penis (e.g. Peryonie's disease), painful erections, sickle cell disease / leukaemia / multiple myeloma, bleeding conditions (e.g. haemophilia), stomach ulcers (e.g. gastric/peptic ulcer)?			
Current Health			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Have you been advised to avoid strenuous exercise?			
Is walking or running difficult for you?			
Do you have symptoms of depression and have not seen a GP?			
What symptoms are you experiencing?			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Do you have difficulty in getting or maintaining an erection?			
GP appointment...			
Tick which of the following applies to you…	***Yes***	***No***	***Add extra details if required.***
Erectile dysfunction can sometimes mask underlying medical conditions; it is recommended that you agree to consult your doctor about this...			
Write below any further information which may be relevant e.g. medicines taking, conditions suffered, concerns...			

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For Official Use

SHIM - Erectile Dysfunction severity indicator test

Over the past 6 months:						
How do you rate your confidence that you could get and keep an erection?		Very Low	Low	Moderate	High	Very High
		1	2	3	4	5
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	No sexual activity	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more that half the time)	Almost most always or always
	0	1	2	3	4	5
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than, half the time)	Almost always or always
	0	1	2	3	4	5
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	Did not attempt intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
	0	1	2	3	4	5
When you attempted sexual intercourse, how often was it satisfactory for you?	Did not attempt intercourse	Almost never or never	A few times (much less than half the time)	Sometimes (about half the time)	Most times (much more than, half the time)	Almost always or always
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5.

TOTAL:_____

The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints:

- 1-7 - Severe ED **Excluded**
- 8-11 - Moderate ED Included
- 12-16 - Mild to Moderate ED Included
- 17-21 - Mild ED **Excluded**

Date	Medicine	Quantity	Details	Price

Additional erectile dysfunction advice

Smoking	☐	Alcohol	☐	Depression	☐
Medicine Side Effects	☐	Patient information leaflet given?	☐	Lifestyle advice	☐

PATIENT CONSENT

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended medicines being given at each appointment*.

Patient Name / signature ...../ ...../ ..... **Date**.....

Do you consent for our pharmacy and/or our authorising medical agency to contact you regarding customer satisfaction? Yes / No

PHARMACIST AGREEMENT

I have consulted the specific PGD which enables me to supply the listed medicine and have found that the patient is included in treatment and there are no valid exclusions applicable. I have given the patient information on the risks and benefits of the medicines recommended and have done my utmost to ensure the patient fully understands them. I have also given the patient the opportunity to ask questions. This will be carried out at each appointment.

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Pharmacist Name / signature ...../ ...../ ..... **Date**.....

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Record of Treatment Provision

New risk assessment form required after 14 consultations

Medicine Supplied	Quantity	Details	Change in medical history	Pharmacist Signature	Price
No.1			Yes ☐ No ☐		
Patient Signature			Date		
No.2			Yes ☐ No ☐		
Patient Signature			Date		
No.3			Yes ☐ No ☐		
Patient Signature			Date		
No.4			Yes ☐ No ☐		
Patient Signature			Date		
No.5			Yes ☐ No ☐		
Patient Signature			Date		
No.6			Yes ☐ No ☐		
Patient Signature			Date		
No.7			Yes ☐ No ☐		
Patient Signature			Date		
No.8			Yes ☐ No ☐		
Patient Signature			Date		
No.9			Yes ☐ No ☐		
Patient Signature			Date		
No.10			Yes ☐ No ☐		
Patient Signature			Date		
No.11			Yes ☐ No ☐		
Patient Signature			Date		
No.12			Yes ☐ No ☐		
Patient Signature			Date		
No.13			Yes ☐ No ☐		
Patient Signature			Date		
No.14			Yes ☐ No ☐		
Patient Signature			Date		