VITAMIN B12 PRESCRIPTION REQUEST FORM

PLEASE COMPLETE DETAILS IN THE BOXES PROVIDED

 USE AN 'X' IN THE BOX TO MARK RELEVANT SELECTIONS

# **YOUR DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| TITLE (MR/MRS/MS) |  | EMAIL ADDRESS |  |
| FIRST NAME |  | TELEPHONE |  |
| LAST NAME |  | DOB |  |

|  |
| --- |
| YOUR HOME ADDRESS |
|  |
| CITY |  | POSTCODE |  |

|  |
| --- |
| GP SURGERY FULL ADDRESS |
|  |
| CITY |  | POSTCODE |  |

# **MEDICATIONS**

PLEASE LIST DOWN ANY MEDICATIONS YOU ARE CURRENTLY TAKING BELOW

|  |
| --- |
|  |

# **CONTRA-INDICATIONS**

PLEASE SELECT ANY CONTRA-INDICATIONS FOR IM HYDROXOCOBALAMIN B12 INJECTION THAT APPLY TO YOU

|  |  |  |  |
| --- | --- | --- | --- |
| NONE | [ ]  | LEBER’S HEREDITARY OPTIC ATROPHY | [ ]  |
| COBALT ALLERGY | [ ]  | PREGNANT | [ ]  |
| COBALAMIN AND DERIVATIVE ALLERGIES | [ ]  | UNDER 18 | [ ]  |
| LOW BLOOD POTASSIUM LEVELS | [ ]  | UNDERGOING CANCER TREATMENT | [ ]  |

# **INDICATIONS**

PLEASE USE AN ‘X’ TO SELECT ANY INDICATIONS FOR IM HYDROXOCOBALAMIN B12 INJECTION THAT MAY APPLY TO YOU.

IF YOU HAVE NO SYMPTOMS LISTED BELOW - PLEASE SELECT ‘OTHER’ AT THE BOTTOM TO ADD ANY OTHER SYMPTOMS, CONCERNS THAT YOU HAVE AND REASONS FOR REQUESTING TREATMENT (SUCH AS LACK OF ENERGY/TROUBLE SLEEPING ETC)

|  |  |  |  |
| --- | --- | --- | --- |
| ABNORMALLY PALE FACIAL COMPLEXION | [ ]  | HYPERSENSITIVITY | [ ]  |
| ACID REFLUX THAT OCCURS REGARDLESS OF DIET | [ ]  | HYPOTHYROID OR HYPERTHYROID DISORDER | [ ]  |
| AGGRESSIVE BEHAVIOUR THAT IS NEW OR UNUSUAL | [ ]  | INFERTILITY | [ ]  |
| ALTERED PALATE, FOOD TASTES DIFFERENT | [ ]  | INSOMNIA OR SPORADIC SLEEP | [ ]  |
| ALWAYS FEELING COLD | [ ]  | INTESTINAL BACTERIAL OVERGROWTH | [ ]  |
| ANXIETY | [ ]  | IRRITABILITY | [ ]  |
| BAD BREATH, HALITOSIS | [ ]  | JOINT PAIN | [ ]  |
| BLURRING OR DOUBLE VISION | [ ]  | LANGUAGE IMPAIRMENTS IN CHILD | [ ]  |
| BRUISE EASILY | [ ]  | LOSING YOUR BREATH EASILY | [ ]  |
| BURSITIS | [ ]  | LOSS OF APPETITE | [ ]  |
| CELIAC DISEASE | [ ]  | LOW SPERM COUNT | [ ]  |
| CHRONIC DAILY FATIGUE | [ ]  | MEMORY IMPAIRMENTS | [ ]  |
| CHRONIC PANCREATITIS | [ ]  | MOOD SWINGS | [ ]  |
| CONFUSION, MUDDLED THINKING, BRAIN FOG | [ ]  | MUSCLE FATIGUE OR STIFFNESS | [ ]  |
| CONSTANTLY ITCHY SKIN | [ ]  | NAUSEA | [ ]  |
| CONSTIPATION | [ ]  | NECK PAIN | [ ]  |
| CONTINUOUS MOUTH ULCERS | [ ]  | NEUROSIS, FIXATIONS | [ ]  |
| CRACKED SORES AT BOTH CORNERS OF YOUR MOUTH | [ ]  | NIGHT TERRORS | [ ]  |
| CROHN’S DISEASE | [ ]  | OCCASIONAL VERTIGO OR ROOM SPINNING | [ ]  |
| DEPRESSION THAT LASTS WITHOUT APPARENT CAUSE | [ ]  | OPTIC NEURITIS | [ ]  |
| DIFFICULTY BUILDING MUSCLE MASS | [ ]  | PERIPHERAL NEUROPATHY | [ ]  |
| DIFFICULTY SWALLOWING | [ ]  | PERNICIOUS ANEMIA | [ ]  |
| DIZZINESS, UNSTEADINESS, POOR STABILITY | [ ]  | PERSISTENT HEADACHES | [ ]  |
| DRY MOUTH, UNPLEASANT TASTE IN MOUTH | [ ]  | PINS AND NEEDLES | [ ]  |
| EARLY ONSET MENOPAUSE | [ ]  | PMS | [ ]  |
| EARLY ONSET DEMENTIA | [ ]  | POOR CONCENTRATION, ADD- LIKE SYMPTOMS | [ ]  |
| EASILY DISTRACTED | [ ]  | POOR CONTROL OF LIMB MOVEMENTS | [ ]  |
| ECZEMA, DRY SKIN RASHES | [ ]  | POOR DEVELOPMENT IN NEWBORN BABY | [ ]  |
| ERECTILE DYSFUNCTION | [ ]  | POOR OR SLOW NERVE REFLEXES | [ ]  |
| ESOPHAGEAL ULCERS | [ ]  | POST-PARTUM DEPRESSION | [ ]  |
| EVERYDAY DIARRHEA | [ ]  | PREMATURE GREY HAIR | [ ]  |
| FIBROMYALGIA | [ ]  | RECURRENT PANIC ATTACKS | [ ]  |
| FLATULENCE | [ ]  | RED TONGUE THAT IS ABNORMALLY SMOOTH | [ ]  |
| FREQUENT CLUMSINESS | [ ]  | REDUCED LIBIDO | [ ]  |
| FREQUENT HEARTBURN, DESPITE EATING HEALTHY | [ ]  | SORE TONGUE, BURNING MOUTH SENSATION | [ ]  |
| FREQUENT MISCARRIAGES, SPONTANEOUS ABORTIONS | [ ]  | STRANGE THIRST, CONSTANTLY DEHYDRATED | [ ]  |
| FREQUENT STOMACH BLOATING | [ ]  | STRICT VEGETARIAN | [ ]  |
| FREQUENT STOMACHACHES | [ ]  | THIN, RIDGED NAILS THAT BREAK EASILY | [ ]  |
| GASTRIC BYPASS SURGERY | [ ]  | TINNITUS | [ ]  |
| HAIR LOSS NOT RELATED TO AGE | [ ]  | UNUSUAL METALLIC TASTE IN MOUTH | [ ]  |
| HALLUCINATIONS, DELIRIUMS | [ ]  | UNUSUAL WEIGHT LOSS OR WEIGHT GAIN | [ ]  |
| HEART PALPITATIONS THROUGHOUT DAY | [ ]  | VEGAN | [ ]  |
| HORMONAL IMBALANCES | [ ]  | WEAK PULSE | [ ]  |
| HYPERACUSIS | [ ]  | YEAST INFECTIONS THAT OCCUR OFTEN | [ ]  |
| HYPERHOMOCYSTEINEMIA | [ ]  | **OTHER** / REASON FOR REQUESTING TREATMENT **(INCLUDE DETAILS BELOW)** | [ ]  |

|  |
| --- |
| **OTHER** (include details here, if applicable) |
|  |

# **COVID - 2 WEEKS CLEAR OF VACCINATION?**

PLEASE PLACE A CROSS IN THE BOX, AS APPROPRIATE

|  |  |
| --- | --- |
| YES | [ ]  |
| NO | [ ]  |

# **VERIFICATION**

PLEASE CHECK THAT ALL INFORMATION YOU HAVE PROVIDED ABOVE IS CORRECT.

|  |  |  |  |
| --- | --- | --- | --- |
| PRINT NAME |  | DATE |   |
| SIGNED |  |