Logo

Description automatically generatedVITAMIN 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

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# **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)

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| --- | --- | --- | --- |
| 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 |  | | |