**PLEASE COMPLETE AND RETURN TO THE PRESCRIBING TEAM**

**Progesterone Only Pill (POP or mini-pill) Request**

(Common examples: Desogestrel/Cerazette/Cerelle, Norethisterone/Micronor/Noriday, Levonorgestrel/Norgeston

The POP is an effective and safe contraceptive method when used correctly. Unlike the combined contraceptive pill we do not need to monitor your blood pressure regularly and there are many fewer contraindications. If you are an established user of this type of pill and wish to continue taking it you can use this form to request your prescription without the need for any appointment. You are still welcome to make an appointment to see a doctor or specialist nurse if you have any queries or concerns, or are considering an alternative method of contraception. You may be asked to make an appointment if any information on this request from suggests this could be beneficial.

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| **NAME** | **Date of Birth:** | **Name of pill:** |

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| --- | --- |
| 1. **Are you aged under 16, or aged over 55?** | **YES (please circle) NO** |
| 1. **Have you missed any pills since your last prescription, or struggle to remember to take you pills?** | **YES NO** |
| 1. **Has there been any change to your usual bleeding pattern since your last prescription?** | **YES NO** |
| 1. **Do you have any side effects from your pill?**   ***If yes then what are the side effects?*** | **YES NO** |
| 1. **Have any new medications been started since your last POP prescription?**   ***If yes then what is this medication?*** | **YES NO** |
| 1. **Would you like *to discuss your pill or contraceptive needs with a doctor or specialist nurse?*** | **YES NO** |
| 1. **Would you like:**   ***Chlamydia screening?***  **To request a chlamydia kit please use the following website:**  [***https://www.sexualhealthcornwall.co.uk/get-help/sti-home-testing/***](https://www.sexualhealthcornwall.co.uk/get-help/sti-home-testing/)  ***Assistance with smoking cessation, and consent to a referral to Healthy Cornwall’s virtual stop smoking team?***  ***Assistance with weight management, and consent to a referral to our social prescribing team?*** | **YES NO**  **YES NO**  **YES NO** |

**FOR PRESCRIBING TEAM USE ONLY:**

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| Check prescription screen: | Pill name : Last prescription date: |
| If **NO** to all questions, and request fits with previous prescription date, then please issue usual POP prescription for 6 months’ supply. |  |
| If **YES to any of questions 1-6** please prescribe 1 month of pills and scan letter to pharmacists.  If **YES to any of answer 7** please prescribe 6 months of pills and task to reception to offer and arrange. |  |
| Once complete please scan into the patient notes. |  |