

URINE SAMPLE DROP OFF QUESTIONNAIRE – IVY GROVE SURGERY

Please complete this form – we will not be able to accept your urine sample without it

Identification – please complete all sections

Full name	
Date of birth	
First line of address	
Who asked for sample?	<input type="checkbox"/> Doctor/nurse <input type="checkbox"/> No-one, I decided myself

Symptoms – please tick any that apply

Duration of symptoms days
<input type="checkbox"/> Pain on passing urine	<input type="checkbox"/> Going to pass urine more often
<input type="checkbox"/> Passing more urine at night	<input type="checkbox"/> Feeling of urgency
<input type="checkbox"/> Lower abdominal pain	<input type="checkbox"/> Smelly urine
<input type="checkbox"/> Cloudy urine	<input type="checkbox"/> Back pain
<input type="checkbox"/> Fever (temperature)*	<input type="checkbox"/> Shaking/shivering*
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Vomiting*
<input type="checkbox"/> Confusion/disorientation*	<input type="checkbox"/> Other info

Female patients only – please tick any that apply

<input type="checkbox"/> I am pregnant	<input type="checkbox"/> I am on my period	<input type="checkbox"/> I have vaginal discharge
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Treatment – please tick any that apply

<input type="checkbox"/> I have tried self-care	<input type="checkbox"/> I have seen or spoken to a chemist
<input type="checkbox"/> Other info	

For office use only

Version 1.0 (Jan 2023)

<input type="checkbox"/> Info added to <i>Urine Sample Drop-off</i> template	<input type="checkbox"/> Bottle labelled correctly
<input type="checkbox"/> Sample sent to nurse for dip	<input type="checkbox"/> Sample sent to lab for testing
<input type="checkbox"/> Duty doctor informed*	<input type="checkbox"/> Added to WLL for review