POSSIBLE URINARY INFECTION

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sample Requested By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Sample: 🞎 Mid-stream urine 🞎 Early morning urine 🞎 Catheter urine

How long have you had symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any treatment for your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following symptoms?

 Getting up through the night to pass urine

 Is the above a new symptom, or is happening more than usual

N/A

 Dysuria (pain passing urine)

New urgency

 New frequency

 New incontinence

 Rigors (Fever) – Please give temperature: \_\_\_­­­­\_\_\_

 Lower abdominal pain

 Vomiting

 Abnormal vaginal discharge (if applicable)

 Delirium (New/worsening confusion)

 Frank haematuria (blood in urine)

Backache

Cloudy urine

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? 🞎 Mild 🞎 Moderate 🞎 Severe

ARE YOU PREGNANT? 🞎 Yes 🞎 No

ARE YOU ON YOUR PERIOD? 🞎 Yes 🞎 No

**PLEASE NOTE IF ALL AREAS OF THIS FORM ARE NOT COMPLETED THE SAMPLE MAY NOT BE PROCESSED.**

Receptionist taken form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_