TOPICAL ANAESTHETIC RISK ASSESSMENT FORM

Date:

Name:	**Ph Number:**	**Medicare:**
Date/Time of Appointment:		
Topical Anaesthetic Request: (Please indicate size) Anaesthetic Gel: 1gm____ 5gm____ 10gm____ Anaesthetic Crm: 1gm____ 5gm____ 10gm____		**Clinic Details:**
Male or Female: (please circle)		**Date of Birth: ____ / ____ / ____**
Patient Address: (include State & Postcode)		
Procedure you are having:		
Current Medication List / Nutrition Supplements:		
Medical History:		
Have you ever suffered any cardiac complaints?: (if yes please provide details) **YES / NO** **Cardiac Medications: YES / NO**		
Allergies and/or Sensitivities: (if yes please list)		
Pregnant or Breastfeeding: YES / NO If yes which one:		
Risk Assessment Conducted – Pharmacist Signature:		

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