****

 **THYROXINE MEDICATION REVIEW**

Completing the following questionnaire will help us update your medication without you having to come to the surgery. This will save you an appointment. Could you kindly answer the following questions:

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **Date of Birth:** |  | **NHS No (if known):** |  |
| **Address:** |  |
|  |
| **Tel No:** |  | **Mobile No:** |  |
| **Email Address:** |  |
|  |
| **All questions marked with an \* must be answered**  |
|  |
|  |
| 1\*  | Do you take your medications regularly?  |
|  | Choose an item. |
|  |  |  |
| 2\*  | Do you have any side-effects from these medications?  |
|  | Choose an item. |
|  | If you have answered YES, please list side-effects: |
|  |  |
|  |
|  |  |  |
| 3\*  | Do you feel the medication is doing what it is meant to do?  |
|  | Choose an item. |
|  |  |  |
| 4\*  | Are you up to date with annual blood tests?  |
|  | Choose an item. |
|  |  |  |
| Once the doctor has reviewed your answers they will check on the system to make sure your blood results are up-to-date and the results do not indicate any need for a dose reduction or increase.  |
|  |  |
|  |  |  |
|  | Today’s Date: |  |

**ACTION NOW REQUIRED:**

Please save this questionnaire to your PC and email it to trentvalley.secretaries@nhs.net.

Alternatively, if you do not have access to email, print a copy and post/ bring to the surgery.

Thank you