**Delay a Period**You may wish to delay a period if it is due at a time that would be inconvenient, such as a holiday or exam. If you are not already taking "the pill" then a hormone tablet could be prescribed for this.

Please complete this form to request a prescription to delay a period.

PLEASE NOTE – THIS FORM MUST BE COMPLETED AT LEAST 2 WEEKS BEFORE YOUR EVENT/HOLIDAY.

**Request for Prescription to Delay a Period**This form provides the GP with important information, including to assess your risk of thrombosis/DVT. Please fully completely the form.

**Full Name** *(required)*Please enter FULL NAME – First name, Middle initial if appropriate and surname
**Date of Birth** *(required)*Your date of Birth

 **Address** *(required)*Your address

DD/MM/YYYY

**Postcode** *(required)*Your postcode

**Contact Number** *(required)*Please enter your mobile or Home Telephone Number

**Date of Event/Holiday** *(required)*AT LEAST 2 WEEKS NOTICE IS REQUIRED BEFORE TRAVEL/EVENT. Please enter the date from which you want to delay your period

**Duration of Event/Holiday** *(required)*Please enter the number of days the event or holiday will last

**Date of expected period** *(required)*Please enter the approximate date your period is expected (in relation to the event/holiday)

DD/MM/YYYY

**Have you personally suffered from a blood clot, or been told you have an increased risk of this condition?** *(required)*Please indicate "Yes" or "No"

**If 'Yes' please provide further details**

**Is there a family history of bloods clots or deep vein thrombosis (DVT)?** *(required)*Please indicate "Yes", "No" or "Unknown"
 **If "Yes", please give further details (Relation/Condition, etc)**

**Current Weight (kg)** *(required)* **Current Height (cm)** *(required)*

**Recent blood pressure reading (if known)**

**Are you a current smoker?** *(required)*Please indicate "Yes" or "No"

**If "yes", please state daily cigarette, cigar or tobacco consumption**Please provide average/approximate daily number of cigarettes/cigars or weight of tobacco.

**Digital signature** *(required)*Please add your name as a digital signature

 **Date of signature** *(required)*

**Declaration** *(required)*I confirm I am the patient specific on the form and that the form has been completed fully and to the best of my knowledge. I agree to contact Fenham Hall Medical Group as soon as possible if I later become aware of any changes.

I confirm I am the patient and agree to the declaration above [ ]

There are several ways to return this form. You can download, complete and email this form to fenhamhallmedicalgroupa86031@nhs.net. You can print, complete and return this form to Fenham Hall Medical Group via post (allowing for the postage time this would take) or hand in at reception. You can also ring the surgery and a member of our Reception Team will go through the form with you over the phone.