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?	☐ **Doctor/nurse** ☐ **No-one, I decided myself**

Symptoms – *please tick any that apply*

Duration of symptoms	**…… days**
☐ **Pain on passing urine**	☐ **Going to pass urine more often**
☐ **Passing more urine at night**	☐ **Feeling of urgency**
☐ **Lower abdominal pain**	☐ **Smelly urine**
☐ **Cloudy urine**	☐ **Back pain**
☐ **Fever (temperature)***	☐ **Uncontrolled shaking/shivering***
☐ **Blood in urine**	☐ **Vomiting***
☐ **Confusion/disorientation***	☐ **Other info ……**

Female patients only – *please tick any that apply*

☐ **I am pregnant**	☐ **I am on my period**	☐ **I have vaginal discharge**

Treatment – *please tick any that apply*

☐ **I have tried self-care**	☐ **I have seen or spoken to a chemist**
☐ **Other info ……**	

For office use only

Version 1.1 (Jan 2024)

☐ **Info added to *Urine Sample Drop-off* template**	☐ **Bottle labelled correctly**
☐ **Sample sent to nurse for dip**	☐ **Sample sent to lab for testing**
☐ **Duty doctor informed***	☐ **Added to WLL for review**