**Information for suspected UTI/Cystitis**

**Patient to complete:**

Date ………………………….

Name……………………………………… D.O.B…………

Address:………………………………………………………………………………………

…………………………………………………………………………………………………

Contact Tel No: ……………………………

Are you suffering from any of the symptoms below? Please delete as appropriate.

1. Pain when you pass water? No/Yes
2. Passing water more often? No/Yes
3. Lower stomach pain ? No/Yes
4. The feeling you need to pass water urgently? No/Yes
5. Have you seen any blood or red/pink colour in your urine? No/Yes
6. High fever/temperature? No/Yes
7. Pain in your back or loins? No/Yes
8. Vaginal discharge or irritation? No/Yes
9. Have you had any shivering or shaking with this illness? No/Yes
10. Do you have a catheter tube to drain your urine? No/Yes

Approximately how many days have you had your symptoms for? …………. Days

Have you ever been admitted to hospital and stayed overnight for treatment of a urine infection? No/Yes

Staff information only – this form is for female patients only aged 18 and over

When a patient brings a sample of urine to reception for ‘query’ UTI or cystitis please ask them to fill in the following form to help us decide if they need treatment, how long they will need treatment for and if the sample should be sent off for further investigation. Please ensure we have a contact number in case we need to contact them for further information.