**Confidential**

Please tick which option you require (or both)

1. A nurse to train the patient in self-administration either at their home or, a nominated health care facility
2. A sharps bin for waste disposal of used pens

Patient Information: Dated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | | | Date of Birth: | |  |
| Home Phone: | | Mobile Phone: |
| Address: | | |
| Male: Female: | | |
| Has the patient previously been prescribed Metoject® injection? Yes: No: | | | | | |
| Prescribing Physician Information: | | | | | |
| Referring Hospital Consultant: | Hospital: | | Phone: | | Email: |
| Nurse Contact Number: | | Fax: | | Address: |
| Diagnosis and Prescription: | | | | | |
| Diagnosis: | | | | | |
| Allergies: | | | | Weight: | |
| Is patient currently on Oral Methotrexate?: Yes: No:  If ‘Yes’, please indicate day this medication is taken: Mon: Tues: Wed: Thurs: Fri: Sat: Sun: | | | | | |
| Is the patient currently on any other medication? Yes: No: | | If yes, please list all medications: | | | |
| Prescription:  Please indicate the presentation of Metoject® 50mg/ml prescribed – tick box:  i.e. 7.5mg 10mg 15mg 20mg 25mg  (Please note these are the only available presentations)  How often is the pen to be administered? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |

All data held by Fannin Limited and their approved license contractors, is for the sole purpose of these Metoject® services

and, is in accordance with the Data Protection Act 1998 and 2003.