Isle of Wight NHS
Primary Care Trust

Date ……

Dear Doctor ……..

Following a consultation with your patient:

Name:	Address: …… …… …… ……
DOB:	

Who has the following symptoms:

	Tick those boxes that apply
Urinary frequency	
Dysuria	
Urgency	
Other*	

(a) I have referred the patient to you as they fall outside of the criteria for the supply of trimethoprim by a pharmacist.

Or**

(b) I have supplied 6 x 200mg Trimethoprim Tablets at a dose of 200mg every 12 hours. The patient has been counselled to contact you if her symptoms do not resolve.

Yours Sincerely,

Pharmacy Stamp

……
Pharmacist
(Please print name below)

……

* Annotate with symptom(s) as appropriate.
**Delete as appropriate.