

**URINE TESTING PROFORMA FOR SUSPECTED URINARY TRACT INFECTION
IN BOTH WOMEN AND MEN OVER 16 YEARS OF AGE or CATHETERISED PATIENTS**

Name: _____ D.O.B: _____ Tel No: _____

Do you have a catheter YES / NO Do you have any allergies YES / NO

Are you/could you be pregnant YES / NO Do you have chronic kidney disease YES / NO

Are you fed by feeding tube YES / NO

WHY ARE YOU HANDING IN A URINE SAMPLE FOR TESTING?

Annual review YES / NO GP/NP request YES/NO name _____

Suspected Urine Infection YES/ NO

Please circle the correct response if any of the following symptoms:

1	Pain/difficulty passing urine	YES / NO
2	Passing urine frequently	YES / NO
3	Urgent need to pass urine	YES / NO
4	Needing to pass urine a night more frequently	YES / NO
5	New incontinence	YES / NO
6	Blood in urine	YES / NO - if yes require triage appointment
7	Lower abdominal pain	YES / NO
8	High temperature	YES / NO
9	Nausea or vomiting	YES / NO
10	A recorded temperature on 2 or more occasions	YES / NO
11	New malaise (generally feeling unwell)	YES / NO
12	New lethargy (feeling tired)	YES / NO
13	New confusion	YES / NO

How long have you had these symptoms? _____

Have you received antibiotic treatment for these symptoms in the past 6 months YES / NO

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