# TOPICAL ANAESTHETICS RISK ASSESSMENT FORM **Date:**

| **Name:** | **Ph Number:** | **Medicare:** |
|---|---|---|
| **Date/Time of appointment:** | | |
| **Topical Anaesthetic Request:**<br>Anaesthetic Gel: 1gm ___ 5gm____ 10gm___<br><br>Anaesthetic Lipoderm: 1gm___ 5gm____ 10gm ___<br>*Please indicate size required.* | Please fill in clinic details here:<br>Australian Cosmetic Tattoo College<br>Suite 13, Level 1, Galleria Building,<br>Cnr Short and William st, Port Macquarie<br>NSW 2444. | |
| **Male or Female:** (please circle) | **Date of Birth**: ____ /____ /____ | |
| **Patient Address:** (include State & Postcode) | | |
| **Procedure you are having:** | | |
| **Current Medication List/Nutrition Supplements:** | | |
| **Medical History:** | | |
| **Have you ever suffered any Cardiac Complaints?:** (If yes please provide details) **Y / N**<br><br>**Cardiac Medications: Y/N** | | |
| **Allergies and/or Sensitivities:** (If yes please list) | | |
| **Pregnant or Breastfeeding: Y/N**<br>If yes which one: _____ | **Is This a New Application: Y/N** | |
| **Risk Assessment conducted – Signature pharmacist:** X _____ | | |

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