Prescriptive Hormonal Contraceptives: Patient Information and Consent

Today's Date:_____ Patient Name:_____ Date of Birth:_____
Last First Middle or Maiden

Parent or Custodian Information

Patient or Custodian Name: _____

Address:_____ City:_____ State:_____ Zip: _____

General Information

Before you give your consent, be sure you understand both the pros and cons of using prescriptive, hormonal contraceptives. This form outlines the possible complications that can occur with prescriptive hormonal contraceptives, and the danger signs you should watch for while using them. If you have questions, we will be happy to discuss them. Your consent is entirely voluntary; you can change your mind at any time.

As you read, please initial each section.

Specific Information

☐ I understand the patch/pill/ring is not 100-percent effective and that an unplanned pregnancy can occur, especially if my weight is over 155 pounds or if I am taking antibiotics or psychiatric medications.

☐ I understand that protections from pregnancy may be lowered when the patch/pill/ring is taken with cenain drugs, including antibiotics, antispasmodics, tranquilizers, antidepressants and antihistamines.

☐ I understand that possible risks from the patch/pill/ring include:

- Increased chance ofdeveloping a blood clot, which may be fatal
- High blood pressure
- Increased chance ofheart attack or stroke, especially in women over 35 or who smoke
- Liver problems, including liver tumors

☐ Other possible patch/pill/ring side effects include:

- Headache
- Eye problems· difficulty with contact lenses
- More frequent urinary tract infections
- Skin rash or symptoms of allergy
- Spotting between periods; light or missed periods
- Delay in resuming menstrual cycles afier stopping hormonal contraceptive
- Nausea
- Acne flare-up
- Weight gain
- Vaginal infections
- Darkening ofthe skin or face

☐ I understand my responsibility to lower my risk ofserious patch/pill/ring complications by calling my clinician if I develop any of the following danger signs:

- Chest pain with shortness of breath, coughing
- Severe headaches with vomiting and dizziness
- Severe abdominal pain.
- Pain or swelling in calfor leg
- Eye problems, blurred vision, or flashing lights

☐ I understand I should also see my clinician if I notice:

- Yellowjaundice
- Severe depression
- A breast lump
- A new mole, or a mole that grows or changes

☐ I am aware that smoking tobacco while using the patch/pill/ring increases my risk of serious cardiovascular events, especially if I am over 35.

☐ I am aware of other methods of birth control, including condoms, spermicidal foam, diaphragm, sterilization, natural family planning, abstinence, etc.

A special note regarding the patch

☐ I understand that hormones from patches applied to the skin get into the blood stream and are removed from the body Differently from birth control pills taken by mouth and that I will be exposed to about 60-percent more estrogen than found in the typical birth control pill. In general, increased estrogen exposure may increase the risk of side effects.

Please return completed form to the appropriate physician's office.

Prescriptive Hormonal Contraceptives: Patient Information and Consent, cont'd.

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Last First Middle or Maiden

Patient Consent

I have read or had read to me the contents of this form, reviewed and understand this list, understand the risks and alternatives of this procedure, and have been given an opportunity to ask any questions I have about this treatment with the provider.

Patient or Custodian Signature:_____ Date:_____

If someone other than the patient or custodian completed this form, please give name & relationship:

_____ _____
Name Relationship

Witness Signature: _____ Date:_____

Address:_____ City:_____ State:_____ Zip: _____

Provider Signature:_____ Date Reviewed:_____

Please return completed form to the appropriate physician's office.