SECTION 2.10
DELAYED EXAMINATION

I. Up to 3 months of hormonal contraception may be provided without a physical examination or laboratory tests as outlined in each hormonal method protocols. Preference should be given to the "Quick Start" approach to initiating the chosen method, as outlined in each hormonal contraceptive protocol. Dispensing of hormonal contraceptives for a Delayed Exam may be done by the RN under Standing Orders, as described in Section 1.8 - Pharmaceuticals in the Nursing Manual and as set out in the individual's job description. If the client is dispensed more than three months of a contraceptive without an exam, documentation must be made in the chart as to why the exam is further delayed. Physical exam delayed beyond 6 months must have documentation of a compelling reason for the delay.

A. First Visit

1. History - A targeted family and personal medical history must be done.
2. Education – Appropriate method counseling, and other topics as indicated.
3. Family Planning Program consent, informed consent for the delayed exam and method consent are required.
4. Medical Evaluation
   a. BP
   b. Urine pregnancy test if indicated.

B. Second Visit

1. History:

   Complete the full history and update any history of side effects, method use, and menstrual history.

2. Education:

   As required for the initial exam.

3. Medical: Physical as outlined in Section 1.4 - Health Care Services of the Nursing Manual.

C. Follow Up

1. It is up to the clinic to decide whether to track delayed exam clients to document whether the clients return within three months for a complete visit, including a complete history and a physical as outlined in Section 1.4 - Health Care Services of the Nursing Manual.
2. If a clinic decides to track clients who do not return, clinic staff may want to attempt to contact them by phone and/or letter. Such attempts to contact should be documented in the chart along with the stated reason for not returning.

The following is a sample of a Delayed Exam Consent Form. This form can be downloaded from the CDPHE Family Planning Program website at:
http://www.cdphe.state.co.us/pp/womens/FPNursingConsntsForms.html.

DELAYED EXAM CONSENT

Name _____ **Date of birth** _____

First day of last menstrual period_____ **Date of last intercourse**_____

Current method of contraception _____**List allergies to medicines** _____

List any medications you are currently taking _____

By signing the consent for delayed exam I agree that:

1. I am voluntarily receiving contraceptives for up to 3 months without having a physical exam. I understand a physical exam may be recommended before additional hormonal contraceptives are given. I also understand that it may be advised that a physical exam be completed before starting this method.

2. I understand that the decision to provide me with this contraceptive method is based only on the information I provide about my medical history, my family history, my weight, and my blood pressure. I understand that any condition about which I fail to inform the clinic staff, and any condition, which currently exists, which could be discovered by physical examination could increase my risk of serious illness or complication. However, I also understand that there is usually nothing found at the time of a pelvic exam that would prevent the use of hormonal contraceptives. I have been told that the purpose of a pelvic exam is primarily to provide me with a Pap test to check for cervical cancer; it may also check for signs of sexually transmitted diseases.

3. I understand that taking hormonal contraception does not protect me from sexually transmitted diseases, and to the best of my knowledge I am not currently infected with a sexually transmitted disease.

4. I have been informed that smoking while taking oral contraceptives/ Evra (patch)/Nuvaring can increase my risk of stroke, heart attack, and other vascular diseases.

5. I have received instruction in the use of the hormonal contraceptive method that I have chosen. I agree to return within three months for **an evaluation of the method I have chosen, and a physical exam if recommended**, and I understand that if I fail to return, the clinic may contact me according to my instructions.

Client Signature _____ Date _____

Staff Signature_____ Date _____

Translator/Interpreter Signature_____ Date _____

STAFF USE ONLY
Are any of the following found in the patient's history?

- ☐ DVT/PE in legs, arms or lungs
- ☐ Family history of clotting disorder
- ☐ Seizures
- ☐ CVA or MI; vascular/ischemic heart disease
- ☐ Active liver disease/ impaired liver function
- ☐ Mother/father/brother/sister died of stroke/heart attack <50 yrs.
- ☐ < 6 weeks postpartum and Lactating or less than 21 days postpartum
- ☐ (If client is less than 42 days postpartum, check additional risk factors for venous thromboembolism (VTE): ☐ ≥ 35 years old, ☐ Thrombophiliea, ☐Immobility, ☐Transfusion at delivery, ☐BMI ≥ 30, ☐Post partum hemorrhage, ☐C/S delivery, ☐ Pre-eclampsia, or ☐Smoking)
- ☐ Migraine HA with focal neurologic sx
- ☐ Cancer
- ☐ Sexually Transmitted Disease
- ☐ ≥ 35 years of age and smokes
- ☐ Systemic Lupus erythematosus
- ☐ Diabetes
- ☐ Peripartum cardiomyopathy

Blood Pressure: _____ Ht. _____ Wt. _____ BMI_____ .

Pregnancy Test: ☐ Pos ☐ Neg ☐ N/A Gravida_____ Para_____

There ☐ ARE ☐ ARE NOT contraindications to starting hormonal contraceptives with a delayed exam.

The following contraceptive method was dispensed to the client with instructions for use:

☐ Oral contraceptive: _____ # of cycles:_____

☐ NuvaRing: # Cycles _____ ☐ Evra: # Cycles _____

☐ DMPA: _____ ☐ Other: _____

Family Planning appointment made for _____

Staff Signature: _____ Date: _____

Provider name and title: _____ Date: _____

SAMPLE