DELAYED PELVIC EXAM CONSENT

Name _____ **Date of birth** _____

First day of last menstrual period _____

Current method of contraception _____

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 smear 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 _____

Witness Signature_____ Date _____

Translator/Interpreter Signature_____ Date _____

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

- ☐ DVT/PE in legs or lungs
- ☐ Diabetes
- ☐ 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
- ☐ Migraine HA with focal neurologic sx
- ☐ Cancer
- ☐ Sexually Transmitted Disease
- ☐ ≥ 35 years of age and smokes
- ☐ Systemic Lupus erythematosus

Pregnancy Test: ☐ Pos ☐ Neg ☐ N/A Blood Pressure: _____ Ht. _____ Wt. _____

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 _____

Provider name and title: _____ Date: _____