Intrauterine Contraception (IUC) Insertion Progress Note

Date: ____________________

Subjective:
Current BCM ____________ LMP __________ Date of last intercourse __________ Allergies __________

_____ IUC information booklet given to and read by client or information discussed with client
_____ Completed IUC counseling and client questions answered by clinician
_____ IUC consent signed and copy given to client

Objective: BP __________ Heart Rate __________ Urine Pregnancy Test Result ____________

Chlamydia/GC Date __________ Results __________ Pap Date __________ Results ___________

HGB Date __________ Results __________

Pelvic Exam  √ If Normal  Comments

<table>
<thead>
<tr>
<th>External genitalia</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vagina</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervix</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wet prep (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uterus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adnexae</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IUC __________ Lot# __________ Exp. Date __________

Betadine prep? (circle) Yes / No  Allergy to Betadine/shellfish prepped with __________

Tenaculum applied to (circle) Anterior or Posterior cervix. Uterus sounded to __________ cm.

IUC strings trimmed to __________ cm / inches.

Post IUC insertion bimanual exam: ____________________________ Post Insertion BP __________ Heart Rate __________

Assessment:
IUC inserted without difficulty? (circle) Yes / No  Comment: ________________________________________________

Procedure well tolerated? (circle) Yes / No

Comments:

Plan:
1. Use backup form of birth control for 7 days (if indicated)
2. Reviewed IUC warning signs. Client to be seen by health care provider if has any warning signs
3. Instructed on checking strings
4. Ibuprofen 400-800 mg po Q 8 hours prn pain/cramping (OTC)
5. If indicated, client instructed to RTC __________ for IUC follow up appointment
6. Client to call or return to clinic with questions, concerns, or complaints
7. RTC for annual visit __________

Comments:

Signature ___________________________  M.D. Signature ___________________________

Date ________________                   Date ________________