

REQUEST FOR PREGNANCY TEST

Please Print

DATE _____ / _____ / _____

NAME _____ Birth Date _____ / _____ / _____ AGE _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

<p>RACE: PLEASE MARK ALL THAT APPLY</p> <p><input type="checkbox"/> African -American (Black)</p> <p><input type="checkbox"/> American Indian/Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Caucasian</p> <p><input type="checkbox"/> Pacific Islander</p> <p><input type="checkbox"/> Other</p> <p>ETHNICITY: Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>How do you feel about becoming pregnant (Check the best answer)?</p> <p>1. <input type="checkbox"/> I wanted to be pregnant sooner</p> <p>2. <input type="checkbox"/> I wanted to be pregnant later</p> <p>3. <input type="checkbox"/> I wanted to be pregnant now</p> <p>4. <input type="checkbox"/> I didn't want to be pregnant</p>
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1. Any symptoms of pregnancy? Yes No If yes, list any symptoms: _____
2. First day of your last period _____
3. Was it a normal period? Yes No
4. When was your last act of intercourse? _____
5. Check the method of birth control used: Pill Shot Condoms Implant IUD Patch Ring None Other _____
6. If the result of the pregnancy test is negative, are you interested in a method of birth control? Yes No
7. If you are pregnant, do you want a referral for: Prenatal Care Abortion Adoption Unsure
8. Who do you see when you get sick? _____
9. How many pregnancies have you had? _____ 10. How many births? _____ 11. How many miscarriages? _____
12. How many abortions? _____ 13. Do you smoke cigarettes? Yes No 14. Household annual income: _____
15. Number in household _____

I request that this clinic provide me with a pregnancy test. I understand if my test is positive, I should have a pelvic exam as soon as possible (within 15 days). If the test is positive, I will give a copy of this form to my health care provider.

Client Signature _____	Date _____	
Test Done	Reason Test Not Done	Test Results
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Date of LMP too recent <input type="checkbox"/> Client left <input type="checkbox"/> Other _____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive LMP _____ EDC _____ Wks. gest. _____

Referral To	Service Provided	Education Given
<input type="checkbox"/> Family Planning Clinic Appt made: <input type="checkbox"/> Repeat Pregnancy Test: Date <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Adoption services <input type="checkbox"/> Abortion Services <input type="checkbox"/> Nurse Family Partnership <input type="checkbox"/> Prenatal Plus <input type="checkbox"/> Medicaid/PE <input type="checkbox"/> WIC <input type="checkbox"/> Public Health Nurse <input type="checkbox"/> STD Clinic <input type="checkbox"/> Substance Abuse Program <input type="checkbox"/> Smoking Cessation	<input type="checkbox"/> Pregnancy Test <input type="checkbox"/> Pelvic Exam (chart details below) <input type="checkbox"/> Counseling - Contraceptive <input type="checkbox"/> Counseling - Adolescent (including abstinence) <input type="checkbox"/> Counseling - Emergency Contraception <input type="checkbox"/> Counseling - Pregnancy Options <input type="checkbox"/> STD Counseling <input type="checkbox"/> Chlamydia test: <input type="checkbox"/> Urine <input type="checkbox"/> Cervical <input type="checkbox"/> Dispensed Condoms and/or foam <input type="checkbox"/> Depo Injection (chart details in comments below) <input type="checkbox"/> Dispensed OCP's _____ <input type="checkbox"/> Quickstart <input type="checkbox"/> Dispensed Evra (patch) <input type="checkbox"/> Quickstart <input type="checkbox"/> Dispensed NuvaRing <input type="checkbox"/> Quickstart <input type="checkbox"/> Dispensed prenatal vitamins/instructions	<input type="checkbox"/> AIDS/ Safe Sex <input type="checkbox"/> All methods/E.C <input type="checkbox"/> Anatomy/Menstrual Cycle <input type="checkbox"/> Comfort measures/pregnancy <input type="checkbox"/> Drug/Alcohol/Smoking Risks <input type="checkbox"/> Exercise <input type="checkbox"/> Ectopic Precautions <input type="checkbox"/> E.R. #'s: <input type="checkbox"/> Folic Acid/Nutrition <input type="checkbox"/> Medication during pregnancy <input type="checkbox"/> Preconception Counseling <input type="checkbox"/> Prenatal Depression <input type="checkbox"/> Cramping/Bleeding <input type="checkbox"/> Toxoplasmosis

Family Planning Program Consent Signed

Objective Findings: B/P: _____ Wt.: _____ Pelvic (if indicated): _____

Other Comments: _____

Staff Signature _____ Date _____