ABCD Family Planning Partnership

Informed Consent for Contraceptive Implant

Name: _____
Date of Birth:_____
Medical Record Number:_____

1. I voluntarily choose and consent to use the contraceptive implant as a method of preventing pregnancy. I consent to the medical treatments, physical exams, procedures, and lab tests my healthcare providers advise are needed for me to use the contraceptive implant.

2. Before making my decision, I received a full explanation of the methods of preventing pregnancy including: the contraceptive implant, progestin-only birth control pills, combined oral contraceptive birth control pills, contraceptive patch, vaginal contraceptive ring, contraceptive injection, hormonal IUD, copper IUD, male condoms, female condoms, sponge, spermicides, emergency contraception, natural family planning, permanent contraception (sterilization), and abstinence (not having sex). I understand that except for abstinence no method of birth control is 100% effective.

2. The risks and benefits of using the contraceptive implant to prevent pregnancy have been explained to me including effectiveness, potential side effects, warning signs, and correct length of use. These are described in the ABCD Contraceptive Implant Fact Sheet, which has been provided to me and I understand.

3. I understand a trained healthcare provider will insert the implant under the skin on the inner side of my upper arm. I understand a trained healthcare provider will need to remove the implant when I need to replace it, if I want to switch to another birth control method, or if I no longer want to use this method to prevent pregnancy.

4. My healthcare provider has explained what to expect during and after the contraceptive implant placement and when I should follow up at the health center. I understand I may experience some pain or bruising on my arm after the implant is put in.

5. I understand that the contraceptive implant will not protect me from HIV or other sexually transmitted diseases (STDs).

6. I was told how to contact the health center if I have questions, concerns, or an emergency.

I understand the above consent form and have been given the opportunity to ask questions.

_____

Signature of Client Date

_____

Signature of Interpreter (If Needed) Date

_____

Signature and Title of Provider Date