ABCD Family Planning Partnership

Informed Consent for Contraceptive Injection (Depo-Provera)

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

1. I voluntarily choose and consent to use the contraceptive injection (Depo-Provera) 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 Depo-Provera.

2. Before making my decision, I received a full explanation of the methods of preventing pregnancy including: the contraceptive injection, progestin-only birth control pills, combined oral contraceptive birth control pills, contraceptive patch, vaginal contraceptive ring, contraceptive implant, 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 injection to prevent pregnancy have been explained to me including effectiveness, potential side effects, and warning signs. These are described in the ABCD Contraceptive Injection (Depo-Provera) Fact Sheet, which has been provided to me and I understand.

3. I understand that Depo-Provera is given by injection (a shot) and that it will prevent pregnancy for 13 weeks. I understand that I must return for a repeat injection of Depo-Provera every 11-13 weeks to continue preventing pregnancy. I received instructions about how and when to follow up at the health center and what to do if I forget to return for repeat injections.

4. I understand that Depo-Provera will not protect me from HIV or other sexually transmitted diseases (STDs).

5. 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