# ABCD Family Planning Partnership

## Informed Consent for Copper Intrauterine Device (IUD)

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

1. I voluntarily choose and consent to use the copper intrauterine device (IUD) 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 copper IUD.

2. Before making my decision, I received a full explanation of the methods of preventing pregnancy including: the copper IUD, progestin-only birth control pills, combined oral contraceptive birth control pills, contraceptive patch, vaginal contraceptive ring, contraceptive implant, contraceptive injection, hormonal 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.

3. The risks and benefits of using the copper IUD 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 Copper IUD Fact Sheet, which has been provided to me and I understand.

4. I understand that the copper IUD will be placed into my uterus by a trained healthcare provider and that I will need a trained healthcare provider to remove the copper IUD 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.

5. My healthcare provider has explained what to expect during and after the copper IUD placement and when I should follow up at the health center. I understand I may experience pain, cramping, or nausea when the IUD is placed and for a short time afterward. I understand I may need help getting home after the IUD is put in.

6. I understand that the copper IUD will not protect me from HIV or other sexually transmitted diseases (STDs).

7. 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