

SUBDERMAL CONTRACEPTIVE INSERTION RECORD

Name _____
Age _____ Date of Birth _____
Allergies _____
Current Method of Contraception _____
Current Medications _____
LNMP _____ Day of client's cycle _____
Last sexual intercourse _____

History

Annual examination within 1 year* yes no
Allergic or hypersensitivity to iodine yes no
Allergic or hypersensitivity to Lidocaine yes no
Allergic or hypersensitivity to any component in implant yes no
Current medications on Appendix D list yes no
Current known pregnancy or suspected pregnancy yes no
Currently breastfeeding (at least 4 weeks postpartum) yes no
Unexplained vaginal bleeding yes no
Known or suspected breast cancer or history thereof yes no
Hepatic disease (tumors, hepatitis, cirrhosis) yes no

Comments _____

BP _____ **Urine Pregnancy Test** (if indicated) pos neg

Date _____ **Interpreter Name** _____

Staff Signature _____

*Patients should be encouraged to receive routine health maintenance, including annual examination. However, initiation or use of contraception should not be delayed or withheld due to a need for routine health maintenance.

**Subdermal Contraceptive Implant
INSERTION RECORD (page 2)**

Name _____
Date _____

Assessment:

Appropriate candidate for implant? yes no
Consent signed yes no

Insertion:

Implant type _____
Insertion site left upper arm right upper arm
Antiseptic iodine alcohol
Anesthetic Lidocaine ____% ____ mL other _____

Implant inserted according to protocol yes no
If no, explain _____

Implant Lot # _____ Expiration. Date _____

Confirm implant placement by palpation yes no
If no, what action planned or taken
 Implant localization protocol initiated yes no
 Referral for localization yes no
 Backup contraception initiated _____

Complete USER CARD and give to client yes no
Complete Patient Chart Label, affix to chart yes no

Difficulty with implant insertion yes no
If yes, specify _____

If implant not inserted:

Condoms offered given
 Combined oral contraceptive initiated Brand name _____
of cycles _____ start date _____
 Other method of contraception initiated/continued/restarted _____

Return Visit _____

Date _____ **Interpreter Name** _____

Chaperone Signature _____

Clinician Signature _____