

REQUEST FOR REPRODUCTIVE HEALTH SERVICES

I, (print or type name) _____,
request family planning and reproductive services from the
_____ (agency name). I understand that I will give a medical
history, have a physical examination, and may get several tests including but not limited
to:

- * Measurement of height, weight, and blood pressure
- * Breast examination
- * Pelvic (vaginal) examination
- * Pap test (Papanicolaou smear) – a screening test for cancer of the cervix and related conditions
- * Male genital examination
- * Screening tests for sexually transmitted infections
- * Urine test to check for diabetes and urine infection
- * Urine and/or blood tests to check for pregnancy
- * Blood tests to check for syphilis
- * anemia, and immunity to rubella
- * Blood test for hemoglobin disorders, when indicated
- * Skin test for tuberculosis (TB), when indicated
- * Other appropriate clinical tests, when indicated

- I understand my health information is confidential. Confidential means that no one outside of the (_____) will be told about my visits or given information about my health care without my written permission. I understand that in certain cases (suspected child abuse/sexual abuse, child neglect) must be reported as required under State and Federal law.
- I understand that I may request information about the different types of approved family planning methods which are available to me. I understand that these methods include, but are not limited to: fertility awareness-based methods, condoms, diaphragm, spermicides (vaginal film, foam, or gel), birth control pills, emergency contraception, intrauterine (IUD), Injectable birth control “shot” (Depo-Provera), birth control skin patch, vaginal ring (NuvaRing) and subdermal “skin implant” (Implanon). With the help of my health care provider I will decide on the family planning method which is best for me.
- If it is found that I have a sexually transmitted infection, bladder infection, or other infection, I may request treatment for the infection. If my test for gonorrhea, chlamydia, syphilis, or HIV is found to be positive, I understand that, by law, this result, or results for any other reportable infections will be sent to the Maryland State Department of Health and Mental Hygiene, Infectious Disease and Environmental Health Administration as required by law.
- I understand that my health is my responsibility. I agree to call the family planning clinic for regular check-ups and to find out the results of my lab tests. I will tell the clinic if I change my address, phone number, or contact information. If I decide not to return to the clinic, I will seek care from another provider.

- I understand that information in my health record may be disclosed in summary, statistical, or other forms without my consent when the information does not identify me by name.
- I voluntarily agree to receive family planning services. I understand that I may withdraw this consent at any time.
- I understand and agree with the above statements. I have had a chance to ask questions and have had my questions answered.

Date: _____ Client Signature: _____

Please complete the following if interpretation of informed consent was required:

An interpreter was offered to the client. yes no

This form has been read to the client in the client's spoken language. yes no

Patient's Language (specify):

Interpreter's Name: (print or type name of interpreter)

Interpreter Services provided by(agency):

Date: _____ Interpreter Signature: _____

Staff Use Only:

By my signature I affirm that:

- The client has read this form or had it read to her by an interpreter.
- The client states that she understands this information.
- The client has indicated that she has no further questions.

Date: _____ Staff Signature: _____
