

INDIVIDUALIZED CONTACT PLAN FOR FAMILY PLANNING

I, (print or type name) _____,
request the following special plan to contact me regarding my family planning visits:

- I agree to call my health care provider for my test results in 10 to 14 days after each clinic visit. I may be asked to call again at a later date if all the test results are not ready.
- I will let the clinic staff know if I change my address, phone number, or my contact information.
- I will keep scheduled appointments so I can continue to receive good health care.
- If I fail to call the clinic within 10 to 14 days of my visit or fail to respond to the above written plan, and if a serious health problem is found, I understand the (agency name) _____ staff may contact me by telephone, letter, or certified letter.
- 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:
