

## CONSENT FOR EMERGENCY CONTRACEPTIVE PILLS

I, (print or type name) \_\_\_\_\_, request emergency contraceptive pills (ECPs) to minimize a possible pregnancy risk. I understand it is not a main method of birth control.

I have received package instructions that have information about the benefits and risks of the ECPs that I have been given.

I understand that taking ECPs does not prevent pregnancy 100% of the time. Some pregnancies do occur. In spite of this, I wish to try to prevent pregnancy at this time.

I understand that the risk of development of birth defects in the fetus is unknown and that if treatment fails, I must accept this risk should I decide to continue with this pregnancy. No known increased fetal risk of congenital anomalies has been detected so far.

I understand that possible side effects of ECPs may include:

- Nausea and vomiting
- Breast tenderness
- Headaches and dizziness
- Tiredness
- Irregular vaginal bleeding
- Abdominal pain
- Menstrual cycle disturbances
- Diarrhea

I understand that if I see a health care provider for any reason before I get my period, I should tell him/her that I have taken ECPs.

I understand that I should expect my period within 1-3 weeks and I agree to have a pregnancy test if it has not occurred within that time. I will inform a health care provider of any severe lower abdominal pain. It may be a sign of a more serious condition such as ectopic pregnancy (pregnancy outside the uterus).

I understand that ECPs will not protect me against pregnancy from unprotected sexual intercourse after I have taken ECPs.

I have had a chance to ask questions and have had my questions answered.

Date: \_\_\_\_\_ Client Signature: \_\_\_\_\_

