

CONSENT FOR IMPLANON™ - SUBDERMAL CONTRACEPTIVE IMPLANT

I, (print or type name) _____,
request Implanon™- subdermal contraceptive implant as my family planning method.

I understand Implanon is good for 3 years of use and I have received a pamphlet that has information about the benefits, risks, and side effects of Implanon.

I understand that no birth control method is perfect and that some women have gotten pregnant while using Implanon (1 out of every 1000 women during the first year of use).

I understand Implanon will not protect me from HIV infection or other sexually transmitted infections and I need to use condoms for protection from these infections.

I understand that certain medicines may interact with the Implanon to decrease the effectiveness of Implanon. I know it is important to tell all my health care providers that I am using Implanon for birth control.

I understand that it is important to tell my health care provider if I have ever had any of the following conditions before using Implanon:

- Blood clots in the lungs, legs, or brain
- Unexplained bleeding from the vagina
- Inflammation of the veins
- Cancer of the breast or uterus
- Liver disease
- Heart disease or stroke

I understand that it is important to tell my health care provider if I have ever had any of the following conditions so my health care provider can explain problems that could happen if I use Implanon:

- Diabetes
- High cholesterol
- Headaches
- Seizures or epilepsy
- Gall bladder or kidney disease
- Depression
- High blood pressure

I understand that side effects sometimes associated with Implanon include:

- Changes in menstrual bleeding pattern, or even no periods
- Spotting or bleeding between periods
- Weight gain
- Headaches
- Acne
- Depression, mood swings, nervousness

I understand that certain problems can be related to the insertion or removal of Implanon:

- Pain, irritation, swelling, or bruising at the insertion/removal site on the arm
- Thick scar tissue around the Implanon making it difficult to remove
- Infection at the insertion/removal site
- Need for hospitalization to remove Implanon (the cost is your responsibility)

I know to watch for "A.C.H.E.S." as danger signals and to contact a health care provider immediately if these signs occur:

- Abdominal pains
- Chest pains or shortness of breath
- Headaches (severe), numbness, or dizziness
- Eye problems such as blurred vision or double vision
- Severe leg pain

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

Date: _____ Client Signature: _____

If translation of CONSENT FOR IMPLANON – SUBDERMAL CONTRACEPTIVE IMPLANT was required:

- A translator was offered to the client. yes no
- The client chose to use her own translator. yes no
- This form has been orally translated to the client in the client's spoken language.
- Language translated: _____
- Translation provided by: _____
(print or type name of translator)
- Translator employed by, or relationship to the client: _____
- Date: _____ Translator Signature: _____

- The client has read this form or had it read to her by a translator or other person.
- The client states that she understands this information.
- The client has indicated that she has no further questions.

Date: _____ Staff Signature: _____

Clinician Signature: _____