

CONSENT FOR ORTHO EVRA® - CONTRACEPTIVE PATCH

I, (print or type name) _____,
request the birth control patch as my family planning method.

I have received a pamphlet (included with each box of patches) that has information about the benefits and risks of the patch and how to properly apply the patch.

I understand that no birth control method is perfect and that some women have gotten pregnant while on the patch (1 out of every 100 women during the first year of use).

I understand the patch will not protect me from sexually transmitted infections and that I need to use condoms for protection from these infections.

I understand that certain medicines may interact with the patch to decrease the effectiveness of the patch. I know it is important to tell all my health care providers that I am on the patch.

I understand that when using the patch, the chances of developing health problems increase with certain conditions such as:

- Cigarette smoking
- High cholesterol
- Age 35 or older
- Diabetes
- High blood pressure

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

- 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 side effects sometimes associated with the patch include:

- Nausea and vomiting
- Weight gain or loss
- Breast tenderness
- Spotting between periods
- Skin irritation

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 understand that by using the birth control patch I will have a higher overall level of estrogen in my body than if I had used the typical birth control pill. This higher estrogen level may increase my risk of side effects, including blood clots in the lungs or legs.

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

Date: _____ Client Signature: _____

If translation of CONSENT FOR ORTHO EVRA – CONTRACEPTIVE PATCH 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 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: _____