

FAMILY PLANNING IMPLANON™
INSERTION RECORD

Name _____

Age _____ Date of Birth _____

Allergies _____

Current Method of Contraception _____

Current Medications _____

LNMP _____ Day of client's cycle _____

Last sexual intercourse _____

History

Annual examination within 1 year yes no

Allergic or hypersensitivity to iodine yes no

Allergic or hypersensitivity to Lidocaine yes no

Allergic or hypersensitivity to any component of Implanon yes no

Current medications on Appendix D list yes no

Current known pregnancy or suspected pregnancy yes no

Currently breastfeeding (at least 4 weeks postpartum) yes no

Unexplained vaginal bleeding yes no

Current thromboembolic disease or history thereof yes no

Known or suspected breast cancer or history thereof yes no

Cerebrovascular or coronary artery disease or history thereof yes no

Hepatic disease (tumors, hepatitis, cirrhosis) yes no

Comments _____

BP _____

Urine Pregnancy Test (if indicated) pos neg

Date _____ **Interpreter Name** _____

Staff Signature _____

**FAMILY PLANNING IMPLANON™
INSERTION RECORD**

Name _____

Clinician Comments _____

Assessment Implanon candidate yes no

Consent signed yes no

Implanon Insertion

Insertion site left upper arm right upper arm

Antiseptic iodine alcohol

Anesthetic Lidocaine _____% _____ mL other _____

Implanon inserted according to protocol yes no

If no, explain _____

Implanon Lot # _____ Exp. Date _____

Confirm implant placement by palpation yes no

If no, what action planned or taken

Implant localization protocol initiated yes no

Referral for localization yes no

Backup contraception initiated _____

Complete USER CARD and give to client yes no

Complete Patient Chart Label, affix to chart yes no

Difficulty with implant insertion yes no

If yes, specify _____

If Implanon not inserted:

Condoms offered given

Combined oral contraceptive initiated brand name _____
of cycles _____ start date _____

Other method of contraception initiated/continued/restarted _____

Return Visit _____

Date _____ **Interpreter Name** _____

Chaperone Signature _____

Clinician Signature _____