

FAMILY PLANNING INDIVIDUALIZED CONTACT PLAN

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

It is my responsibility to call the clinic 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.

It is my responsibility to let the clinic know if I change my address, phone number, or my contact information.

I will call for 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 Health Department staff may contact me by telephone, letter, or certified letter.

I understand and agree with the above statements.

Date: _____ Client Signature: _____

If translation of FAMILY PLANNING INDIVIDUALIZED CONTACT PLAN was required:

- A translator was offered to the client. yes no
- The client chose to use his/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 the form or had it read to him/her by a translator or other person.
- The client states that he/she understands this information.
- The client has indicated that he/she has no further questions.

Date: _____ Staff Signature: _____