

PREGNANCY TESTING ENCOUNTER RECORD

Name _____

Age _____ Date of Birth _____

Allergies _____

Current Method of Contraception _____

Current Medications (prescription, OTC, vitamins, herbal) _____

Last Normal Menstrual Period (LNMP) _____

Last bleeding episode, if not LNMP _____

Reason for requesting pregnancy test _____

Positive urine pregnancy test: (check all that apply) **EDC (by LMP)** _____

- Verification form given
- Options counseling
- Multivitamin with folic acid recommended
- Prenatal education
- Prenatal care recommended
- Refer for supportive services (WIC, MCHP, Healthy Start, DSS)

Negative urine pregnancy test: (check all that apply)

- Repeat pregnancy test recommended if no menses in 2 weeks
- Preconception counseling
- Family planning appointment given Date _____ Time _____
- Contraception education
- Emergency contraception offered given
- Condoms offered given
- Quick Start contraception initiated (name) _____
- Multivitamin with folic acid recommended

I understand that the pregnancy test is not always 100% accurate and that actual diagnosis of pregnancy or other condition depends on a clinical evaluation which should be performed in 2 weeks. I assume full responsibility for any decisions I make. I have been offered non-directive options counseling and state without reservation that I have not been influenced or advised by any member of the Health Department staff to accept any one particular option.

Date _____ Client Signature _____

Interpreter Signature _____ CHN Signature _____