



Imara Mediplus Centre Family Planning Informed Consent Form:

Name:	Age:
IMC No:	Date:

I, _____, do hereby give my consent to the medical staff of the above named facility to examine, treat and counsel me.

I understand and agree with the following:

- I understand that covered family planning services include routine family planning visits to initiate, continue or discontinue a contraceptive method. Additional covered family planning services may include, but are not limited to, provision of contraceptive methods and pregnancy testing and counseling.
- I understand there are certain hazards and risks connected with all forms of medical treatment and care, which may result in additional costs to me (the client).
- I understand that no form/method of contraception is 100% effective against preventing pregnancy. However if used correctly and consistently medical contraception is close to 99% effective.
- I understand that only condoms offers protection against sexually transmitted diseases including the HIV virus.
- I realize that I should abstain from intercourse or use an additional reliable contraceptive during the first week of hormonal contraception but would be best to use condoms all the time.
- I am aware that the following symptoms are serious and if I experience any of them I should return to the clinic or a physician:
 - A** = Abdominal pain (severe)
 - C** = Chest pain (severe), cough, shortness of breath
 - H** = Headaches (severe), dizziness, weakness, numbness
 - E** = Eye problems (vision loss or blurring), speech problems
 - S** = Severe leg pain (calf or thigh)
- In addition, I am aware that I must see my practitioner if I develop depression, yellow jaundice, or a breast lump
- I am aware that the following side effects – while extremely rare – might occur while I am using the birth control pill:
 - Blood clots of the legs or the lungs
 - Strokes or heart attacks
 - Gall bladder disease

- A type of liver tumor
- I understand that some minor and usually temporary side effects might occur while I am taking hormonal contraceptives including but not limited to:
- spotting or staining between periods
 - diminished menstrual flow
 - breast tenderness or enlargement
 - weight gain (couple pounds -cyclic prior to menses)
 - headache
 - depression
 - elevated blood pressure
 - nausea
 - infections of the vagina
- I understand that there is no guarantee of payment by insurance or by an aid program for any costs that the family planning program does not cover and for which I am responsible.
- I understand that I may be billed for non-Title X services including but not limited to: colposcopy, HIV testing, Chlamydia screening if not at risk, complications resulting from Title X-covered procedures, side effects, from medications, etc.
- I agree to a physical exam, if one is recommended.
- I understand that my provider might recommend lab tests if indicated.
- I understand that all information about me will be kept in strictest confidence and will not be released to anyone without my permission, except as required by law. This could include:
- positive test results of some sexually transmitted diseases,
 - sexual or physical abuse of minors, or
 - physical signs of domestic violence.
- I understand that this facility may use a countrywide database that makes my health information available to the Ministry of Health and other participating family planning programs.

Female clients only:

- I agree to have a pelvic examination including a Pap smear, if recommended. I understand a Pap smear may not be recommended every year.
- I understand that the test for cancer of the cervix (Pap smear) is a screening test only and may produce false negatives (cancer is present but the test says it is not) as well as false positives (cancer is not present but the test says it is).
- I understand the Pap smear may not have enough information to make a diagnosis and may have to be done again.
- I have read the above information. It has been explained to me and I believe I understand it. My questions have been answered by a person from the agency/clinic.

Signature of client _____ Date _____

The client received the above information and I believe she or he understands it.