

**CONTRACEPTIVE IMPLANT CONSENT FORM**

**BENEFITS:** Contraceptive implants consist of one capsule that holds a small amount of birth control hormone, etonogestrel. This medicine is slowly released under my skin to help keep me from getting pregnant for 3 years. I understand that the contraceptive implant is over 99% effective.

**RISKS:** I understand that I should not use the contraceptive implant if I have any of the following conditions, which **I do not have: pregnancy** or active breast cancer. I understand that I may have changes in my menstrual bleeding. It may be irregular, lighter or heavier or my bleeding may completely stop. I am aware that some of the less common side effects include headaches, feeling more nervous, a little weight gain and depression. It is possible I may develop a tiny scar or infection at the insertion site.

I have been told that in order to lessen the chances of serious problems, it is my responsibility to contact a hospital emergency room, a doctor or this clinic if I start having any of the following symptoms: severe headaches, blurred vision or loss of vision, pain in legs, abdominal pain, chest pains, breast lump, severe depression, yellowing of skin, heavy vaginal bleeding, if I suspect I am pregnant, if I cannot feel the contraceptive implant rod under the skin in the arm where it was placed or if I have pain, pus or discomfort at the site of insertion.

I understand that the contraceptive implant does not protect against HIV and other sexually transmitted infections. I understand that I should use condoms consistently and correctly if there is any chance that I am infected or that I am having intercourse with someone who is infected.

I am aware that certain drugs may make the contraceptive implant less effective. These drugs are commonly used for treatment of seizures (epilepsy) and tuberculosis (TB). If I am under treatment with these or any other drugs, I will tell my clinician.

**ALTERNATIVES:** Other means of contraception have been explained to me.

**INQUIRIES:** I have been given the chance to get answers to my questions about this method and this consent form.

**DECIDING TO STOP USING IMPLANON/NEXPLANON:** I have the right to request that the contraceptive implant be removed at any time. I understand the capsule should be removed from my arm after it has been in place for three years. I understand that any care outside the health office for problems related to the contraceptive implant is at my own expense.

**EXPLANATION OF PROCEDURE:** I understand the capsule is inserted just under the skin of my upper arm. It will be placed with a narrow tube after cleaning my skin with an antiseptic and injecting local pain medicine. My arm will be bandaged for a one day and bruises may appear.

I understand the removal procedure is similar to placement. It consists of skin cleaning, the injection of pain medication and a small cut through which the capsule is removed with forceps. I understand that removal involves a small risk of infection or other complications; that it usually takes longer than insertion, and that bruising is common. In a few cases, two visits are needed to remove the capsule.

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**DOCUMENTATION:** I have read and understand the information in this consent form. I have had all my questions about the contraceptive implant answered. I do not believe there is any chance I might be pregnant. I am aware that the contraceptive implant is not 100% effective but my chances of becoming pregnant while using it correctly are very low. (check whichever applies, and sign below)

I am voluntarily requesting the insertion of the contraceptive implant.

I am voluntarily requesting the removal of the contraceptive implant.

Client Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Client Signature: \_\_\_\_\_

Counselor signature: \_\_\_\_\_ Date: \_\_\_\_\_