





Affix Label Here

Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**VOLUNTARY REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I have been given information about the test(s), treatment(s), procedure(s) contraceptive method(s), to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Maryland's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Planned Parenthood of Maryland's notice of health information privacy practices.

Please note that Planned Parenthood of Maryland is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

Signature of Client **X** \_\_\_\_\_ Date \_\_\_\_\_

I witness the fact that the client received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

<input type="checkbox"/> <b>CHECK HERE IF CLIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW</b>	
Signature of any other person consenting <b>X</b> _____	Date _____
Relationship to client _____	
I witness the fact that the client's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.	
Signature of Witness _____	Date _____

*Client must review and sign PPMPF 112 every three years OR if the last consent signed was PPMPF 112, Rev 03/2007 or earlier.*

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DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Birth Control Method Check**

Reason for today's visit: \_\_\_\_\_ Age: \_\_\_\_\_

Are you still using your hormonal birth control method?  Yes  No  
If not, when did you stop? \_\_\_\_\_ Why? \_\_\_\_\_

What birth control method are you using? \_\_\_\_\_  
How long have you used this method? \_\_\_\_\_

What was the first day of your last menstrual period? \_\_\_\_\_  
Was it normal (timing, amount of bleeding)?  Yes  No

Please indicate if you have had any of the following **since starting this method**:

Yes	No		Yes	No	
		Change in headaches			Nausea
		Chest pain			Severe abdominal pain
		Arm pain			Depression
		Leg pain			Yellowing of skin or eyes
		Visual changes			Bleeding between periods
		Numbness or tingly feeling			

Yes No

Do you have questions about your method? \_\_\_\_\_

Have you been late with or forgotten to use your contraception? \_\_\_\_\_

Are you on any medication other than birth control? If yes, list: \_\_\_\_\_

Have you or your partner had a new or more than one sexual partner in the past 3 months?  
# of partners you have had in past 12 months: \_\_\_\_\_  
Partners are:  Men  Women  Both  Trans

Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be? \_\_\_\_\_

Do you protect yourself from STIs? If yes, how? \_\_\_\_\_

Do you smoke cigarettes, cigars, pipes, or chew tobacco? How much per day? \_\_\_\_\_

Are you familiar with Emergency Contraception (EC) and that you can buy it without a prescription if you are ≥17 years old? Do you know when and how it can be used? \_\_\_\_\_

**FILL OUT THIS SECTION IF YOU ARE UNDER 18 YEARS OLD**

Yes No

Are your parent(s)/guardian(s) aware of your visit to Planned Parenthood of Maryland? \_\_\_\_\_

Are you in a relationship where you are being forced to have sex? \_\_\_\_\_

**CLIENT SIGNATURE**

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.  
Client Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\* Staff Use Only \*\*\*

**SUBJECTIVE (HPI) – Extended HPI**

**HCA COMMENTS**

\_\_\_\_\_

\_\_\_\_\_

Hx Reviewed HCA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLINICIAN COMMENTS**

\_\_\_\_\_

\_\_\_\_\_

Hx Reviewed Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\* Staff Use Only \*\*\*

**PAST / FAMILY / SOCIAL HISTORY**

Medical History	Family History	Social History
<input type="checkbox"/> N/A (unless method change) <input type="checkbox"/> No Change <input type="checkbox"/> Changes include: _____	<input type="checkbox"/> N/A (unless method change) <input type="checkbox"/> No Change <input type="checkbox"/> Changes include: _____	<input type="checkbox"/> No Change <input type="checkbox"/> Changes include: _____

History reviewed from:  Past History Form: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Method Check = "pertinent PFSH"; Method Change = "complete PFSH")

**OBJECTIVE (PE)**

Ht.	Wt.	BMI	BP	UPT: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA
<input type="checkbox"/> A & O x 3 <input type="checkbox"/> NAD <input type="checkbox"/> Apparent distress: _____			<b>LABS SENT OUT:</b> <input type="checkbox"/> Chlamydia <input type="checkbox"/> GC <input type="checkbox"/> Other _____	

**ASSESSMENT**

Yes	No	
		Appropriate to continue using _____; no contraindications
		Desires to change method to _____; no contraindications
		Appropriate for immediate use of EC
		Appropriate for STI screening
		Smoker?

Other: \_\_\_\_\_

**Education Done &/or Literature Given**

CIICs/Clis provided in language other than English: <input type="checkbox"/> Spanish  <input type="checkbox"/> Nutrition _____ <input type="checkbox"/> Exercise  <b>Client Information for Informed Consents (CIICs)*</b> <input type="checkbox"/> The Pill, The Patch, The Ring <input type="checkbox"/> Special Considerations <input type="checkbox"/> DMPA <input type="checkbox"/> EC <input type="checkbox"/> POPs <input type="checkbox"/> Implants <input type="checkbox"/> IUC <input type="checkbox"/> RX Barriers  Other CIICs: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____  Other: <input type="checkbox"/> Safety Card Given <input type="checkbox"/> HPV Vaccine Information Given	<b>Client Information (Clis)*</b> <input type="checkbox"/> Instructions: The Pill <input type="checkbox"/> Instructions: The Patch <input type="checkbox"/> Instructions: The Ring <input type="checkbox"/> Male/Female Condoms <input type="checkbox"/> Preg Testing, Eval & Options <input type="checkbox"/> Spermicide for Birth Control <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Calcium & Vitamin D <input type="checkbox"/> Iron-Rich Foods <input type="checkbox"/> Tips for Losing Weight <input type="checkbox"/> Vaginal & Vulvar Health <input type="checkbox"/> Contra Choices <input type="checkbox"/> STI Facts <input type="checkbox"/> GYN Visit  Other Clis: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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\*As of current year's MS&Gs

**PLAN**

<input type="checkbox"/> Problem List / Medication Record updated <input type="checkbox"/> Condoms offered/encouraged <input type="checkbox"/> Risks/benefits of BCM reviewed <input type="checkbox"/> DMPA <input type="checkbox"/> 104mg SQ / <input type="checkbox"/> 150 mg IM q 12 wks x _____ <input type="checkbox"/> Given today <input type="checkbox"/> OCs _____ Sig: 1 qd x _____ # _____ today <input type="checkbox"/> NuvaRing PV X _____ days / out _____ days x _____ # _____ today, Refrigerate <input type="checkbox"/> Ortho Evra 1 patch/wk X 3, none for 1 wk x _____ # _____ today <input type="checkbox"/> Continue BCM as directed <input type="checkbox"/> Start: <input type="checkbox"/> Today <input type="checkbox"/> Day _____ p menses onset <input type="checkbox"/> Use BUM X 7 days <input type="checkbox"/> ECP _____: <input type="checkbox"/> 1.5 mg PO now. If no menses, repeat UPT in 2 wks. <input type="checkbox"/> May refill prn x 1 yr <input type="checkbox"/> Start BCM no later than following AM <input type="checkbox"/> If ≥40, mammogram/CBE encouraged <input type="checkbox"/> WWE encouraged – Due _____ RTC _____ for _____  _____ _____ _____ _____ _____ <input type="checkbox"/> Interpretation provided by PPM <input type="checkbox"/> Interpretation provided by client's preferred interpreter (_____)
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Total time spent with clinician: \_\_\_\_\_  
 Spent >50% of time counseling/education)

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If under 18, parental involvement  previously indicated  encouraged