PREGNANCY TESTING

PATIENT LABEL Date:_____________

☐Consent for Request for Medical Services ☐Pregnancy CIIC Form

MEDICAL HISTORY

Date of Last Period __________ Birth Control Method _____________________

1. Menstrual period on time ☐ Yes ☐ No
2. Normal menstrual flow ☐ Yes ☐ No
3. Bleeding or spotting since LMP ☐ Yes ☐ No
4. New pain in abdomen or pelvis ☐ Yes ☐ No
5. New shoulder pain ☐ Yes ☐ No

(If yes to #4 and #5, staff must consult with Clinician)

Comments:

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OFFICE USE ONLY

Urine HCG result: ❑ Positive ❑ Negative Staff Initials__________

- ❑ Pregnancy Options Discussed: ●Continuation of Pregnancy ●Adoption ●Abortion
- ❑ Option pamphlet
- ❑ Prenatal Vitamin Rx
- ❑ UTI pamphlet/screen
- ❑ Birth Control Pamphlet
- ❑ STI pamphlet/screen
- ❑ Fertility pamphlet
- ❑ Prenatal Provider List
- ❑ Appointment scheduled at PPECI
- ❑ Other referral: _______________________

Staff Signature: ___________________ Clinician Signature: _______________________