

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

DATE: \_\_\_\_\_ PATIENT #: \_\_\_\_\_

NAME OF PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

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 have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my health care visits.

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 understand that a new Pennsylvania law requires PPSP to give me written notification if a serious event compromising patient safety occurs under specific circumstances and that this notification will be sent to the mailing address listed on my contact sheet.

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 Southeastern Pennsylvania'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 voluntarily request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, or HIV antibody test, if I request it).

**I hereby acknowledge** receipt of Planned Parenthood Southeastern Pennsylvania's Notice of Health Information Privacy Practices.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

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

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

Date \_\_\_\_\_

**Contact /Personal Information**

|   |                            |  |                          |
|---|----------------------------|--|--------------------------|
| Patient Number _____  |                            | Today's Date _____                                 |                          |
| Name _____  |                            | Nickname _____                                     |                          |
| First   | Last                       | (optional)   |                          |
| Address _____ / _____ / _____ / _____   |                            |  |                          |
| Street  | Apt#                       | City   | State      Zip           |
| Is it O.K. for us to contact you by mail at above address?  |                            | [ ] Yes  | [ ] No                   |
| If yes, can we use a Planned Parenthood envelope?   |                            | [ ] Yes  | [ ] No                   |
| Address for mail, if different from the one above:  |                            |  |                          |
| _____ / _____ / _____ / _____   |                            |  |                          |
| c/o Name  | Street                     | Apt#   | City      State      Zip |
| Can we use a Planned Parenthood envelope at this address?    [ ] Yes    [ ] No  |                            |  |                          |
| Your Telephone numbers  |                            |  |                          |
| Phone 1 ( _____ ) _____ (home) (work) (cell) Best time to call? _____   |                            |  |                          |
| May we say "Planned Parenthood" to anyone who answers at this number?    [ ] yes    [ ] no; Code name: _____  |                            |  |                          |
| Phone 2 ( _____ ) _____ (home) (work) (cell) Best time to call? _____   |                            |  |                          |
| May we say "Planned Parenthood" to anyone who answers at this number?    [ ] yes    [ ] no; Code name: _____  |                            |  |                          |
| Marital status:    [ ] Married    [ ] Not Married   |                            |  |                          |
| Social Security Number _____ - _____ - _____  |                            | [ ] Female    [ ] Male                             |                          |
| Birth Date ____ - ____ - _____    Age _____   |                            | <b>Staff Use Only:</b> ID Verified: [ ] yes [ ] no |                          |
| Referred By: How were you referred to us?   |                            |  |                          |
| [ ] Other Planned Parenthood Site   | [ ] Drove/walked by Center | [ ] Family/Friend                                  | [ ] Internet             |
| [ ] Newspaper Ad  | [ ] CHOICE Hotline         | [ ] Doctor   | [ ] Yellow Pages         |
| [ ] Program done by PPSP  | [ ] School/College         | [ ] Other _____                                    |                          |
| Sometimes Planned Parenthood likes to contact patients for your suggestions or to give you information. May we:   |                            |  |                          |
| [ ] Call to get your opinion over the telephone about your patient care experiences?  |                            |  |                          |
| [ ] Send you information about Planned Parenthood from any of its departments in a Planned Parenthood envelope?   |                            |  |                          |
| [ ] Please do not contact me for these purposes.  |                            |  |                          |
| Who can we contact if unable to reach you or in case of emergency? <b>(This information is legally necessary):</b>  |                            |  |                          |
| Name _____  |                            |  |                          |
| First   | Last                       |  |                          |
| Address _____   |                            |  |                          |
| Bldg #  | Street                     | Apt#   | City      State      Zip |
| Phone Number ( _____ ) _____  |                            |  |                          |
| Does this person know you are here [ ] Yes    [ ] No    Relationship _____  |                            |  |                          |
| Should we (1) use a Planned Parenthood envelope or (2) plain envelope (circle the appropriate number)   |                            |  |                          |
| Is it (1) OK to say Planned Parenthood to anyone who answers or (2) should we only use Planned Parenthood when speaking to the contact person? (Please circle appropriate number) |                            |  |                          |
| What is the name of your family doctor?   |                            |  |                          |

Patient Name \_\_\_\_\_

Patient Number \_\_\_\_\_

The information below is for statistical use only. No person will be excluded from services at Planned Parenthood Southeastern Pennsylvania based on duration of residency, citizenship, national origin, race, sexual orientation, marital status, religion, color, sex, method of referral, or contraceptive preference. With Census 2000, the Federal government introduced the option for choosing multiple races. Please choose from the lists below.

What county do you live in:

- Chester County, PA     Delaware County, PA     Montgomery County, PA     Philadelphia County, PA
- Other Pennsylvania County \_\_\_\_\_ (which county?)     Other State \_\_\_\_\_ (which state?)

Race/ Ethnicity

- |   |  |
|---|--|
| <input type="checkbox"/> (04) Asian   | <input type="checkbox"/> (21) Asian + Black + Pacific Islander/Native Hawaiian   |
| <input type="checkbox"/> (01) Black/African-American  | <input type="checkbox"/> (22) Asian + Black + White  |
| <input type="checkbox"/> (03) Native American/Alaskan Native  | <input type="checkbox"/> (23) Asian + White + Pacific Islander/Native Hawaiian   |
| <input type="checkbox"/> (07) Pacific Islander/Native Hawaiian  | <input type="checkbox"/> (24) Black + White + Native American/Alaskan Native   |
| <input type="checkbox"/> (02) White   | <input type="checkbox"/> (25) Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian                |
| <input type="checkbox"/> (08) Asian + Black   | <input type="checkbox"/> (26) Black + White + Pacific Islander/Native Hawaiian   |
| <input type="checkbox"/> (09) Asian + Native American/Alaskan Native                                    | <input type="checkbox"/> (27) White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian                |
| <input type="checkbox"/> (10) Asian + Pacific Islander/Native Hawaiian                                  | <input type="checkbox"/> (28) Asian + Black + White + Pacific Islander/Native Hawaiian                                 |
| <input type="checkbox"/> (11) Asian + White   | <input type="checkbox"/> (29) Asian + Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian        |
| <input type="checkbox"/> (12) Black + Native American/Alaskan Native                                    | <input type="checkbox"/> (30) Asian + Black + White + Native American/Alaskan Native                                   |
| <input type="checkbox"/> (13) Black + Pacific Islander/Native Hawaiian                                  | <input type="checkbox"/> (31) Asian + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian        |
| <input type="checkbox"/> (14) Black + White   | <input type="checkbox"/> (32) Black + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian        |
| <input type="checkbox"/> (15) Native American/Alaskan Native + Pacific Islander/Native Hawaiian         | <input type="checkbox"/> (33) Asian + Black+ White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |
| <input type="checkbox"/> (16) White + Native American/Alaskan Native                                    | <input type="checkbox"/> (05) Other or Unknown   |
| <input type="checkbox"/> (17) White + Pacific Islander/Native Hawaiian                                  |  |
| <input type="checkbox"/> (18) Asian + Black + Native American/Alaskan Native                            |  |
| <input type="checkbox"/> (19) Asian + Native American/Alaskan Native + Pacific Islander/Native Hawaiian |  |
| <input type="checkbox"/> (20) Asian + White + Native American/Alaskan Native                            |  |

Are you of Hispanic origin?  yes  no

What is your primary language? (if not English)

- |  |                                    |                                   |                                     |   |
|--|------------------------------------|-----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Albanian                      | <input type="checkbox"/> Chinese   | <input type="checkbox"/> Hindi    | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Ukranian               |
| <input type="checkbox"/> Arabic                        | <input type="checkbox"/> Creole    | <input type="checkbox"/> Ibo      | <input type="checkbox"/> Russian    | <input type="checkbox"/> Urdu                   |
| <input type="checkbox"/> Bosnian/Croatian              | <input type="checkbox"/> Ethiopian | <input type="checkbox"/> Laotian  | <input type="checkbox"/> Spanish    | <input type="checkbox"/> Vietnamese             |
| <input type="checkbox"/> Cambodian                     | <input type="checkbox"/> French    | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Tagalog    | <input type="checkbox"/> American Sign Language |
| <input type="checkbox"/> Cantonese                     | <input type="checkbox"/> Greek     | <input type="checkbox"/> Polish   | <input type="checkbox"/> Turkish    |   |
| <input type="checkbox"/> Other _____ (which language?) |                                    |                                   |                                     |   |

Are you a student:  yes  no

What is the highest grade you have completed (do not include the one you are in now)? \_\_\_\_\_

If you are in high school, middle school, junior high or elementary school, what is the name of your school?  
\_\_\_\_\_

Current Birth Control Method:

- |  |  |
|--|--|
| <input type="checkbox"/> Birth Control Pills                           | <input type="checkbox"/> Patch (Ortho Evra)                      |
| <input type="checkbox"/> Cervical Cap                                  | <input type="checkbox"/> Other                                   |
| <input type="checkbox"/> Condom - female                               | <input type="checkbox"/> Spermicide                              |
| <input type="checkbox"/> Condom - male                                 | <input type="checkbox"/> Sponge                                  |
| <input type="checkbox"/> Condom and Spermicide                         | <input type="checkbox"/> Sterilization                           |
| <input type="checkbox"/> Depo-Provera                                  | <input type="checkbox"/> None – pregnant                         |
| <input type="checkbox"/> Diaphragm                                     | <input type="checkbox"/> None – seeking pregnancy                |
| <input type="checkbox"/> Implanon                                      | <input type="checkbox"/> None – not currently sexually active    |
| <input type="checkbox"/> IUD   | <input type="checkbox"/> None – not at risk of becoming pregnant |
| <input type="checkbox"/> Natural Family Planning / Fertility Awareness | <input type="checkbox"/> None – not interested or undecided      |
| <input type="checkbox"/> NuvaRing                                      |  |

**STI HISTORY & PHYSICAL**

**Patient Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Medical Record #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**SUBJECTIVE/CHIEF COMPLAINT: Why are you here today?**  Routine Screening  Problem \_\_\_\_\_

**How do you identify?**  Female  Male  Transgender Other, please identify: \_\_\_\_\_

- No Yes**
- Are you receiving medical care with another health provider? Reason for visit(s): \_\_\_\_\_
- Are you allergic to any medications, metals, foods, anesthesia or other products? List: \_\_\_\_\_
- Are you currently taking medications (including herbal remedies and vitamins)? List: \_\_\_\_\_

|   |   |  |
|---|---|--|
| <p><b>FAMILY HISTORY</b> – Has your Grandmother/father (GM/GF), Mother (M), Father (F), Sister (S), or Brother (B) been diagnosed with any of the following?</p> <p><b>No Yes</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Breast cancer family member: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Ovarian cancer family member: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Uterine cancer family member: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate cancer family member: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Testicular cancer family member: _____</p> <p><b>PAST MEDICAL HISTORY</b> – Have <b>YOU</b> been diagnosed or treated for any of the following:</p> <p><b>No Yes</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney / Urinary Tract problems or infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Genital problems / surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Pelvic infection / PID</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Pap smear</p> <p><input type="checkbox"/> <input type="checkbox"/> Serious illness or hospitalization</p> <p><input type="checkbox"/> <input type="checkbox"/> Vaccination for Hepatitis B</p> <p><b>REVIEW OF SYSTEMS</b></p> <p><b>No Yes</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Constitutional: Fever/Weight Change/ Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> Oral: Ulcers / Sores in your mouth</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin: Rash / Itching</p> <p><b>HEALTH HABITS / SOCIAL HISTORY</b></p> <p><b>No Yes Do you:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Douche.</p> <p><input type="checkbox"/> <input type="checkbox"/> Smoke: _____ cigarettes per day.</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol intake: _____ drinks per week.</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug use: daily / weekly / monthly.</p> <p>Type _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol and/or drugs cause problems in your life?</p> <p><input type="checkbox"/> <input type="checkbox"/> Others concerned with your alcohol/drug habits?</p> <p><input type="checkbox"/> <input type="checkbox"/> Afraid of your partner(s) / others?</p> <p><input type="checkbox"/> <input type="checkbox"/> Parent(s) or guardian is aware of your visit (Only answer if under age 18.)</p> <p><b>SEXUAL HISTORY</b></p> <p>Date you last had sex _____</p> <p># of sexual partners in last 30 days: _____</p> <p># of sexual partners in last 12 months: _____</p> <p># of partners in your lifetime: _____</p> <p>Partner(s) – Check all that apply: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p><input type="checkbox"/> Transgender <input type="checkbox"/> Intersex</p> <p>Kind of sex: (please indicate all that apply):</p> <p><input type="checkbox"/> Vaginal (Giver/ Receiver)</p> <p><input type="checkbox"/> Anal (Giver/ Receiver) <input type="checkbox"/> Oral (Giver/ Receiver)</p> <p><b>No Yes Do you or have you:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Consistently use condoms/dental dams for safer sex?</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever exchanged sex for money or something else you wanted?</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever been forced to have sex?</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever had a partner that had more than 1 partner?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have any of your partners used IV drugs?</p> | <p align="center"><b>INTERVIEWER COMMENTS</b></p> | <p><b>CONTRACEPTIVE HISTORY</b></p> <p>Current method of birth control: _____</p> <p><b>MENSTRUAL HISTORY</b></p> <p><input type="checkbox"/> Check here if this section is not applicable.</p> <p>When was the <b>1<sup>st</sup> day</b> of your last period? _____</p> <p><b>No Yes</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Was your last period normal?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you think you might be pregnant?</p> <p><b>STI HISTORY</b> – Have you ever had the following?</p> <p><b>No Yes</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Chlamydia Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Gonorrhea Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> HPV/warts Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Syphilis Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Trichomonas Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis Date last treated: _____</p> <p><b>STI TREATMENT</b></p> <p><b>No Yes</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Are you here for STI treatment?</p> <p><input type="checkbox"/> <input type="checkbox"/> Is your partner(s) being treated for an STI?</p> <p>Date of treatment _____</p> <p>Name of infection _____</p> <p><b>HISTORY OF CURRENT COMPLAINT-</b> Do you have any of the following?</p> <p><b>No Yes</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Genital sores, itching or pain.</p> <p><input type="checkbox"/> <input type="checkbox"/> Penile/Vaginal discharge.</p> <p><input type="checkbox"/> <input type="checkbox"/> Scrotal/Testicular enlargement.</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain / bleeding with sex.</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain, burning, difficult or frequent urination.</p> <p><input type="checkbox"/> <input type="checkbox"/> A fever or any flu-like symptoms.</p> <p>Date symptoms first noticed: _____</p> <p><b>I would like the following STI screening today:</b></p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Syphilis</p> <p><b>I would like information on the following:</b></p> <p><input type="checkbox"/> Chlamydia _____</p> <p><input type="checkbox"/> Gonorrhea _____</p> <p><input type="checkbox"/> HIV _____</p> <p><input type="checkbox"/> HPV / warts _____</p> <p><input type="checkbox"/> Syphilis _____</p> <p><input type="checkbox"/> Breast Self Exam _____</p> <p><input type="checkbox"/> Testicular Self Exam _____</p> <p align="right">Given (Staff Initials)</p> |
|---|---|--|

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Interviewer Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Medical Record #: \_\_\_\_\_ Date: \_\_\_\_\_

**Interviewer Notes:**

- Safer sex and condom use reviewed
- ECP discussed
- HIV testing offered
- STI Risk Assessment done
- Pt. urged to discuss visit with parent/guardian

Interviewer Signature: \_\_\_\_\_

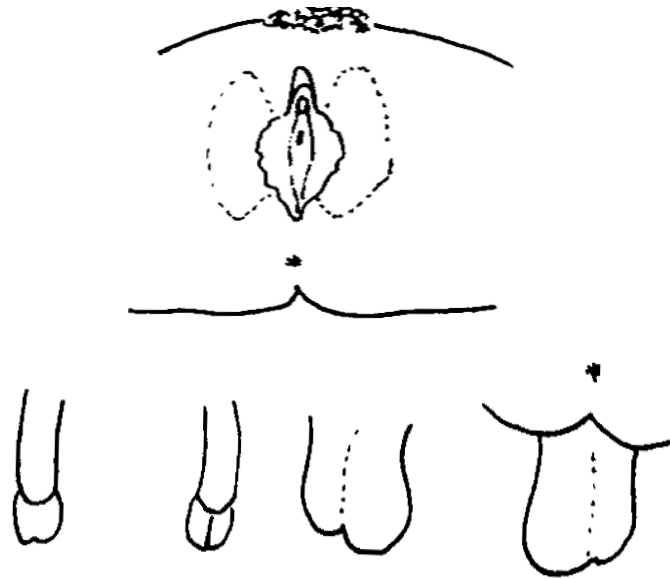
**OBJECTIVE:**

**Laboratory:**

- |                          |                          |                          |                          |            |                              |                              |                              |              |                  |
|--------------------------|--------------------------|--------------------------|--------------------------|------------|------------------------------|------------------------------|------------------------------|--------------|------------------|
| No                       | Yes                      | Pos                      | Neg                      | Wet Mount: | <input type="checkbox"/> No  | <input type="checkbox"/> Yes | pH _____                     | WBCs _____   | Clue Cells _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Whiff:     | <input type="checkbox"/> Neg | <input type="checkbox"/> Pos | <input type="checkbox"/> N/A | Hyphae _____ | Trich _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |                              |                              |                              |              |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |                              |                              |                              |              |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |                              |                              |                              |              |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |                              |                              |                              |              |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |                              |                              |                              |              |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |                              |                              |                              |              |                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |            |                              |                              |                              |              |                  |
- UTI Dipstick: Glucose \_\_\_\_\_ Protein \_\_\_\_\_ Nitrites \_\_\_\_\_ Leukocytes \_\_\_\_\_

**Medical Examination:**

1. Constitution:  
BP: \_\_\_\_\_ Temp: \_\_\_\_\_
- |                                   |                             |                              |                          |
|-----------------------------------|-----------------------------|------------------------------|--------------------------|
|                                   | Normal                      | Variant                      | Not done                 |
| 2. Skin                           | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| 3. Lymph                          | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| 4. Abdomen                        | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| 5. <u>Genitourinary - Female</u>  |                             |                              |                          |
| Urethra                           | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| Vulva                             | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| Vagina                            | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| Cervix                            | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| Uterus                            | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| Adnexa R                          | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| L                                 | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| 6. <u>Genitourinary - Male</u>    |                             |                              |                          |
| Penis                             | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| Scrotum                           | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| Testes                            | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| 7. Gastrointestinal               |                             |                              |                          |
| Rectal inspection                 | <input type="checkbox"/>    | <input type="checkbox"/>     | <input type="checkbox"/> |
| 8. Psychological - Acute distress | <input type="checkbox"/> No | <input type="checkbox"/> Yes |                          |



Dorsal      Ventral      Anterior      Posterior

Self- Testicular Exam Taught/ Pamphlet given     N/A

**ASSESSMENT AND PLAN:**

- Pt. approved for UPT/STI Screen PRN
- Pt. OK for ECP x 1 year:  No  Yes  N/A
- Plan B \_\_\_\_\_ LoOvral 8/Levlen 8 \_\_\_\_\_

- Spent >50% of time counseling. Total time with clinician \_\_\_\_\_
- Implications of not obtaining follow up as recommended discussed
- Additional fact sheets/CHC given \_\_\_\_\_

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