HORMONAL CONTRACEPTION
INFORMED CONSENT FORM

Name _____ Date of Birth_____
Address _____ Phone ( )_____

Date of last menstrual period ____/____/____
Mo Day Year

Before giving your consent, be sure that you understand both the pros and cons of hormonal contraception. If you have any questions, we will be happy to discuss them with you. Do not sign your name at the end of this form until you have read and understood each statement and the pharmacist has answered your questions and can witness your signature. This information is confidential.

I, (print or type name) _____ am requesting participation in the pharmacist prescribed hormonal contraception program.

I understand that:

- I have received and read the patient information sheet regarding the benefits and risks of hormonal contraception and have had an opportunity to ask questions.
- I am required to complete the hormonal contraception screening process.
- No birth control method is 100% effective.
- It can take at least 7 days for hormonal contraception to start working and that I will need to use an alternative form of birth control, such as condoms, during those first 7 days.
- Hormonal contraception will not protect me from sexually transmitted diseases, and that I need to use condoms for protection from these diseases. I understand that I should seek diagnosis and treatment if I am concerned about this and understand that the Centers for Disease Control and Prevention (CDC) recommend screening for STDs, women 25 years old and younger, and women identified with particular risk factors.
- Certain medicines may interact with hormonal contraception. I know that it is important to tell the pharmacist all of the medications, prescription, over-the-counter, and herbals, that I am taking.
- If I encounter any abnormal symptoms (i.e. fever, painful discharge or urination, soreness in the pelvic area) while taking hormonal contraception treatment, I will report any new or worsening physical symptoms to the prescribing pharmacist or my primary care provider immediately.
- It may be useful to share this treatment information with my regular health care provider. Therefore, I request and authorize the release of this information to the following designated provider. **Yes____ No_____**

Designated Provider's Name _____

Patient Signature: _____Date: _____

Pharmacist Signature: _____Date: _____

Prescription:_____

Patient Education Given:_____