CONSENT FOR SUBDERMAL CONTRACEPTIVE IMPLANT
(OR USE MANUFACTURERS CONSENT FORM)

I, (print or type name) ____________________________, request subdermal contraceptive implant (IMPLANON®/NEXPLANON®) as my family planning method.

I understand the implant is good for 3 years and I have received information about the benefits, risks, side effects, and the use of a subdermal contraceptive implant as my method of birth control.

I understand that no birth control method is perfect and that some women have gotten pregnant while using the implant (1 out of every 1000 women during the first year of use).

I understand the implant will not protect me from HIV infection or other sexually transmitted infections and I need to use condoms for protection from these infections.

I understand that certain medicines may interact with the implant to decrease the effectiveness of the implant as a contraceptive. I know it is important to tell all my health care providers that I am using an implant for birth control.

I understand that it is important to tell my health care provider if I have ever had any of the following conditions before using a subdermal contraceptive implant:

- Blood clots in the lungs, legs, or brain
- Unexplained bleeding from the vagina
- Inflammation of the veins
- Cancer of the breast or uterus
- Liver disease
- Heart disease or stroke

I understand that it is important to tell my health care provider if I have ever had any of the following conditions so my health care provider can explain problems that could happen if I use a subdermal contraceptive implant:

- Diabetes
- High cholesterol
- Headaches
- Seizures or epilepsy
- Gall bladder or kidney disease
- Depression
- HIV / AIDS

I understand that side effects sometimes associated with the subdermal contraceptive implant include:

- Changes in menstrual bleeding pattern, or even no periods
- Spotting or bleeding between periods
- Weight gain
- Headaches
- Acne
• Depression, mood swings, nervousness

I understand that certain problems can be related to the insertion or removal of the implant:

• Pain, irritation, swelling, or bruising at the insertion/removal site on the arm
• Thick scar tissue around the implant making it difficult to remove
• Infection at the insertion/removal site
• Need for hospitalization to remove the implant (the cost is your responsibility)
• IMPLANON®/NEXPLANON® must be removed at the end of three years, but can be removed sooner if I want.
• If I have trouble finding a healthcare provider to remove IMPLANON®/NEXPLANON®, I can call 1-877-IMPLANON® (1-877-467-5266) for help.

I know to watch for “A.C.H.E.S.” as danger signals and to contact a health care provider immediately if these signs occur:

• Abdominal pains
• Chest pains or shortness of breath
• Headaches (severe), numbness, or dizziness
• Eye problems such as blurred vision or double vision
• Severe leg pain

I have had a chance to ask questions and have had my questions answered.

Date: ________ Client Signature: __________________________________________________________

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Please complete the following if interpretation of informed consent was required:

• An interpreter was offered to the client. Yes No
• This form has been read to the client in the client’s spoken language. Yes No
• Patient's Language (specify): __________________________________________________________
• Interpreter Name: _________________________________________________________________
  (print or type name of interpreter)
• Interpreter Services provided by (agency): ______________________________________________
• Date: ________ Interpreter Signature: _________________________________________________

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