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Last updated: 02/03/05

Colposcopy Chart Form

Date: ______________________________

G ______P _______Age: _____________

LMP: ______________________________

BCM: ______________________________

Age 1st Coitus: ______________________

Lifetime Sex Partners: _______________

DES exposure: _______________________

STD Hx: ___________________________

External HPV: _______________________

Smoking Hx: ________________________

Pre Meds: __________________________

Consent signed? ❑ Yes ❑ No

Age when first pap: ____

Age when first abnormal pap: ____

What year cryo, LEEP, or other treatment done: ______________________________________

Results and dates of last 3 pap smears: ____

Results and dates of prior colposcopy exams: ____

____

W = aceto white
P = punctation
M = mosaic
V = abnl vessels

Pap ____
GC ____

CT ____

Examination

Gross Lesion: ❑ Yes ❑ No
Adequate: ❑ Yes ❑ No
❑ Yes with speculum
ECC: ❑ Yes ❑ No
Pap collected: ❑ Yes ❑ No
Biopsies #: __________________________

Imp: ______________________________

____

Plan

____

____

____

If treatment needed would cryo probe be adequate? ❑ Yes ❑ No

Counseling

_________Stop smoking
_________Importance of follow-up
_________Nothing in vagina x 3 days

____
Signature

Pathology Review/Patient Contact

Results:

Pap: ____

ECC: ____

Biopsy: ____

Plan: ❑ Pap F/U ❑ Refer for treatment ❑ Refer for further evaluation ❑ Other
❑ Pap in one year ❑ If persists RTC for colpo

____
Signature Date

Place Patient Information Sticker Here

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Xerox with Procedure Consent on reverse side

Consultation/Referral Request

Client Name: ____

Interpreter needed? ☐ YES ☐ NO Language: ______________________________

Client phone number (provide enough information to facilitate contact): ____________________

____

Consult/Referral (Whom/Where will be this referral be sent): ____________________

____

Reason for Consultation/Referral:

____

____

____

____

Please send a written report of the consultation to the following provider at the indicated address:

______________________________ ______________________

Referring Provider (Print Name Legibly) Date

☐ **Auburn Public Health Center (206) 296-8400**
20 Auburn Ave., Auburn, WA 98002

☐ **Columbia Public Health Center (206) 296-4650**
4400-37th Ave. So., Seattle, WA 98118

☐ **Downtown Public Health Center (206) 296-4755**
2124-4th Ave., Seattle, WA 98121

☐ **Eastgate Public Health Center (206) 296-4920**
14350 S.E. Eastgate Way, Bellevue, WA 98007

☐ **Federal Way Public Health Center (206) 296-8410**
33431 13th Place So., Federal Way, WA 98003

☐ **Kent Teen Clinic (206) 296-7450**
613 W. Gowe, Kent, WA 98032

☐ **North Public Health Center (206) 296-4765**
10501 Meridian Ave. North, Seattle, WA 98133

☐ **Northshore Public Health Center (206) 296-9787**
10808 N.E. 145th Street, Bothell, WA 98011

☐ **Renton Public Health Center (206) 296-4700**
3001 N.E. 4th, Renton, WA 98056

☐ **White Center Public Health Center (206) 296-4620**
10821-8th Ave. S.W., Seattle, WA 98146

Place Patient Information Sticker Here
OR Name & DOB

CS 13.22.95, 450-0024
Last updated: 06/07/02

Contraceptive Implant Insertion or Removal Procedure Form

Age: ______ G: ______ P: ______ LMP: _______ Current Contraception: ______________________ Any UPIC? _______

Date of Last Delivery: __________________ Lactation: ❑ Yes ❑ No Plans future children? ❑ Yes ❑ No

Both Insertion and Removal Procedures:

❑ PHSKC FP Informed Consent for Contraceptive Implant System placement/removal has been signed and all questions answered.

❑ Insertions:

- ❑ No contraindications to method.
- ❑ Has documented pap/breast exam within past 12 months.
- ❑ Counseling about decision, risks, side-effects, complications and benefits discussed.
- ❑ Documented to have no allergy to lidocaine, betadine, or tape.
- ❑ Is aware of irregular menstrual bleeding including amenorrhea with method and still wants method.
- ❑ Is aware implant does not provide protection against STIs.
- ❑ No pregnancy or risk of pregnancy at the time of insertion.
- ❑ Desires long term protection against pregnancy

Reason for choosing contraceptive implant: ____

Plans for back-up contraception if needed: ____

Procedure Note for Insertion:

Type of implant system: ❑ Implanon Lot #: __________ Expiration date: ___________

BP____________ Pulse __________ Weight _________ If HCG test performed for insertion: ❑ Negative ❑ Positive

The ventromedial surface of the non-dominant ____________ arm was cleansed with ❑ betadine or ❑ chlorhexidine *(check one)* and a sterile field created. Lidocaine 1% ____________ mL with epinephrine 1:100,000 was injected intradermally into the planned insertion site. The implant was inserted according to the implant system protocol. Both provider and patient were able to palpate the implant at the end of the procedure ❑ yes ❑ no. Site steri-stripped and compression dressing applied. Procedure tolerated _____________. ❑ Complications none, or describe below:

____

Post Insertion:

- ❑ Aware of need for backup method for 1 week if not inserted cycle day less than day 5.
- ❑ Follow-up appointment made, including repeat HCG test if appropriate.
- ❑ Patient education sheet/package insert given to client.
- ❑ Advised to call if fever or signs of infection.
- ❑ Advised, date system will no longer be effective: _________________

❑ Removals:

Reason for contraceptive implant removal: ____

- ❑ Counseling about decision, risks, side-effects, complications and benefits discussed.
- ❑ Plans for contraception, including EC, after removal made. ____

Procedure Note for Removal: Lidocaine 1% ____________ mL with epinephrine 1:100,000 was injected intradermally into the planned removal site The implant was removed according to the implant system protocol. The patient was shown the implant. Time for removal: ________.

Procedure tolerated _____________. ❑ Complications none, or describe below:

____

❑ Interpreter present for visit. Signature/Title:____________________________Date:

Procedure Form: Contraceptive Implant Insertion or Removal

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Public Health & Seattle & King County
999 Third Ave, Suite 900
Seattle, WA 98104
Phone: 206-296-4600

PH- #### (Re v. 6/07)

Client Name: ____

HR #: ____

D.O.B. : ______________________

EDUCATION COUNSELING RISK REDUCTION (ECRR) DOCUMENTATION

Date: ___/___/______	
a) Help client (male or female) critically evaluate which contraceptive method is most acceptable and which method he/she can most effectively use.	Time spent: _______ (Minutes)
b) Assess and address other client personal considerations, risk factors, and behaviors that impact her/his use of contraception.	Time spent: _______ (Minutes)
c) Facilitate discussion of the male role in a successful use of chosen contraceptive method, as appropriate (for himself or for his female partner).	Time spent: _______ (Minutes)
d) Facilitates the client's contingency planning (the "back-up method") regarding the client's use of contraception, including planning for emergency contraception.	Time spent: _______ (Minutes)
e) Schedule follow-up appointments for birth control evaluation at or before 3 months, or as appropriate for the method chosen.	Time spent: _______ (Minutes)

Total Time Spent: ___________

____
Provider (MD / ARNP) Signature Date

____
Educator (RN / MA) Signature Date

Education Counseling Risk Reduction (ECRR) Documentation

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Public Health -Seattle & King County
999 Third Avenue, Suite 900
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236
TTY Relay: 711

Client Name: ____

HR #: ____

D.O.B.: ________________________

Rev (3/06)
1202M

Distribution: White - Health Records

Visit Date:	Age:	LNMP:
Gravida:	Para:	LC:
SAB:	TOP:	Lactating: ☐ Y ☐ N
History of EC in past:	☐ Y ☐ N	
Problems with EC:	☐ Y ☐ N	

Current BCM:	
Allergies:	☐ NKDA
Medications:	☐ None

Reason for ECP (Note: If client is currently pregnant, ECP may be given for future use)

☐ Possible future need

☐ Emergent need (Check one of the following)

☐ condom broke ☐ missed OCPs ☐ method not used correctly ☐ no method used

☐ other:

Coital Hx: Hours since UPIC: ☐ <24 ☐ 24-48 ☐ 49-72 ☐ 73-120 ☐ >120 (not effective)

Multiple UPIC: ☐ Y ☐ N

Candidate for ECP: ☐ Y ☐ N

☐ Emergent Need and / or

☐ Future Possible Need

UCG: ☐ Negative ☐ Positive

☐ Not done (Check reason below and/or explain)

☐ Advanced provision of EC for birth control back up

☐ Advanced provision of EC for use after current pregnancy ends

☐ Client within 6 wks PP or post AB

☐ Other:

☐ Meets criteria and standing order protocol used.

☐ Plan B for emergent use: (2 pills Levonorgestrel 750 mcg each).

☐ Plan B for future use: (2 pills Levonorgestrel 750 mcg each). Take with in 120 hours (5 days) following future UPIC or potential method failure.

☐ Other:

☐ Birth control method desired:

☐ If contraceptive method requires prescription then refer to clinic for family planning services.

☐ Referred to site:

Notes:

Counseling Provided:

☐ ECP risk, benefits and side effects discussed.

☐ If vomits 2 hours from ingestion (<5% risk of this) client needs to repeat dose.

☐ Advised to call for clinic appointment after future ECP use (to assess birth control needs).

☐ Advised about STD prevention, condoms, and importance of STD screening.

☐ Advised if no bleeding in 3 weeks pregnancy possible and could be ectopic so needs to see a provider.

☐ Other:

Affix pharmacy label here

Affix pharmacy label here

PHN Name: ______________________________

PHN Signature: ______________________________ Date: ______________

Order: Emergency Contraception Standing Order

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Family Planning Division
Public Health – Seattle & King County
401 Fifth Avenue, Suite 1300
Seattle, WA 98104
Phone: 206-296-4600
Fax: 206-296-0166

Form #: PH-#### (Rev. 11/07)

Client Name: ______________________

HR #: ______________________

D.O.B.: ______________________

Inventory #: 450-XXXX

Distribution: White – Health Records

Endometrial Biopsy Procedure Chart Form

Age: ______ G: ________ P: ________ LMP: ________ Last Pap Date:___________Results:____________
Current Contraception: ______________ Date of last delivery: _______________
History of abnormal uterine bleeding: ____
❑ Past/current treatment ____
History of: ❑ Pelvic infection, ❑ STD ___________, ❑ Fibroid, ❑ Thyroid disorder, ❑ Other______________
Prior EMB, D&C, TVS: Date:_________ Results_________________________ HCG__________ ❑ Not done
Single current partner of what duration: ____________ years ____________ months

Reason for EMB:

- ❑ Abnormal uterine bleeding
- ❑ Post-menopausal bleeding
- ❑ Prior endometrial hyperplasia
- ❑ Amenorrhea
- ❑ Unopposed estrogen therapy
- ❑ Hereditary nonpolyposis colon cancer
- ❑ Tamoxifen therapy
  - ❑ Endometrial cells on pap and post-menopausal
- ❑ Infertility evaluation
- ❑ ____

Accepts possible risks:

- ❑ Cramping pain during procedure and 1-2 days after procedure
- ❑ Bleeding, (may occur for several days after procedure)
- ❑ Infection
- ❑ Perforation of uterus
- ❑ Allergic reaction to medications or instruments used
- ❑ Vasovagal reaction
- ❑ Disruption of unknown pregnancy
- ❑ Missed abnormal tissue

Procedure Note:

❑ PHSKC Informed Consent for EMB signed and placed in chart
❑ Denies allergy to ❑ betadine, ❑ lidocaine, ❑ benzocaine latex, ❑ ____________________
Premedication;____
Bimanual exam results: ❑ AV/AF ❑ midline ❑ RV/RF ❑ small, firm, non-pregnant, symmetric ❑ other: _________
Cervical os cleaned with: ❑ betadine ❑ _____________ ❑ BP________ ❑ Pulse _________
Tenaculum placed on cervix: ❑ Anterior ❑ Posterior ❑ Not done
❑ 20% benzocaine applied to cervix ❑ 1% lidocaine paracervical injection
Sounded uterine depth: ____________________ ❑ NA:
Type of endometrial catheter: ❑ Pipellep Other_________________
❑ Endometrial catheter easily passed through internal os or ____
❑ Endometrial catheter placed to fundus, suction created; endometrial tissue ❑ scant, ❑ adequate, ❑__________
❑ Collected tissue placed in formalin
❑ Tenaculum removed, hemostasis confirmed ❑ NA
❑ Tolerated procedure well
❑ No complications, or ____
❑ Given advice to: ❑ call for fever, excess bleeding or pain.
❑ pelvic rest for 3 days
❑ NSAIDS post procedure if needed
❑ F/U post-procedure to discuss EMB pathology results

NOTES:

____ ❑ Interpreter present and assisted with visit
MA\RN Provider Signature/Title Date

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Place Patient Information Sticker Here

CC:	
Allergies	☐ NKDA
Medications:	☐ None
Tobacco use:	☐ None
Housing status:	☐ Not homeless

Visit Date:	Age:	
Gravida:	Para:	LC:
BP:	Pulse:	
Wt:	Ht.:	BMI:
Temp:		
Annual Due:		
Last Pap:	Result:	

Current Contraception:

LMP:			
Date last pregnancy ended:			
Lactating: Y N			
Current BCM:			
Uses BCM as prescribed	Y	N	N/A
If Depo last given <_ 13 wks	Y	N	
Satisfied with current BCM	Y	N	
Amenorrhea	Y	N	
Bleeding between periods	Y	N	
New symptoms or problems	Y	N	
Aches now?	Y	N	N/A

UPIC	Y	N
Within: 6-14 days / 5 days		
Hours since UPIC: < 24 24-48 49-72 73-120 >120		
Due to: condom failure No BCM BCM mistake other:		
Multiple UPIC	Y	N
Wants EC	Y	N
STD Concerns	Y	N
Past STD History	Y	N
Current STD symptoms	Y	N
Symptoms in partners:		
Exposure:		
# partners / last 2 months:		
Time w/current partner:		

HPI:____

____

____

____

ROS: *(check if assessed)*

☐ Constitutional ☐ GI ☐ GU ☐ Musculoskeletal ☐ Skin/Breast ☐ Neuro ☐ Psych ☐ CV ☐ Resp ☐ ENT ☐ Eyes

Positive for: ____

History: ☐ Reviewed Medical History form ☐ No change Changes: ______________________

PMH/SH/FH: ____

____

____

____

Exam:	WNL	ABN	N/A	Comments
General				
Thyroid				
Breasts				
Heart				
Lungs				
Abdomen				
Skin				
Extremities				
Psych				

Pelvic: ☐ Pelvic exam deferred

	WNL	ABN	N/A	Comments
Lymph Nodes				
Urethra / Bladder				
Vulva				
Vagina				
Discharge				
Cervix				
Uterus				☐ Ant ☐ Post ☐ Mid Size:
Adnexa				
Anus				

Visit: Female Family Planning / STD

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401 Fifth Avenue, Suite 1000
Seattle, WA 98104
Phone: 206-263-3854
Fax: 206-205-6236

Form #: PH-0084 (Rev. 10/07)

1202M

Client Name: ______________________

HR #: ______________________

D.O.B.: ______________________

Inventory #: 450-0493

Distribution: **White – Health Records**

Stat Labs: ☐ UCG: neg pos ☐ urine dip *(results in lab tab)* ☐ KOH: neg pos ☐ WHIFF: neg pos ☐ Hct. / Hgb________ ☐ pH:____________ ☐ saline clue trich WBCs ☐ Other: ____________________

Labs Sent: ☐ CT ☐ GC ☐ Pap ☐ RPR ☐ Hep B ☐ Hep C ☐ HSV ☐ Urine culture ☐ HIV requested/recommended

☐ Other: ____________________________________

Outside Records: ☐ Ordered ☐ Reviewed

Counseling / Coordination of Care

☐ STD / HIV prevention ☐ Cervical Cytology / HPV ☐ Relationship Safety ☐ Family Involvement
☐ Tobacco cessation ☐ Breast self-exam / Screening ☐ Calcium ☐ Healthy Eating / Active Living
☐ Substance Use ☐ Pre-conception ☐ Iron ☐ Other: ____________________

BCM Education

	BCM desired		Back up method for 7 days
	How method works		Personal BCM routine
	How to start and use method		STD / HIV protection needed
	How to correct birth control mistakes		BCM consent form signed
	Side effects, benefits, risks		BCM brochure given
	Warning signs for estrogen use		EC: How it works, effectiveness, side effects, how to use

☐ **More than 50% of time spent on counseling and coordination of care.** Total time spent in visit: __________ minutes

Orders: **Pill / Patch / Ring:** Brand ________________ ☐ Same day start ☐ Start ____________ ☐ UCG in 2-4 weeks
May use for: _____ months / cycles **Then needs**: ☐ Annual visit ☐ Refill visit
If revisit is normal: _____ months / cycles may be given

Depo: ☐ Same day start ☐ UCG in 2-4 weeks
May use for: _____ months / cycles **Then needs**: ☐ Annual visit ☐ Refill visit
If revisit is normal: _____ months / cycles may be given

Site: ___________ Lot: ___________ Next Shot due: ____________________ ______________________________
Signature of injection provider

EC / Plan B: # packs dispensed: ____________ Stat
packs dispensed: ____________ Advance ☐ May refill as needed

Assessment / Plan / Follow-up:

____
____
____
____
____
____
____
____
____
____
____
____
____
____

MA / RN / Health Educator Date Provider Date

Visit: Female Family Planning / STD

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Seattle, WA 98104
Phone: 206-263-3854
Fax: 206-205-6236

Form #: PH-0084 (Rev. 10/07)

Client Name: ____________________________
HR #: ____________________________
D.O.B.: ________________

Inventory #: 450-0493

Distribution: **White – Health Records**

Please answer the questions below:

Last Name	First	Date of Birth	Age	Date Today
Home Phone Number ( )	Message / Pager Number ( )	Best Time to Call		

What is the main reason for your visit today? ____________________

Are you allergic to any medicines, shellfish, or copper? ☐ No ☐ Yes, which ones, ____________________

What happened ____________________

Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day? ☐ No ☐ Yes

If Yes, list them: ____________________

Yes	No	Have you ever had or do you have:	Yes	No	
☐	☐	Diabetes	☐	☐	Problems with your kidneys or bladder
☐	☐	Seizures	☐	☐	Bone disease or weak bones
☐	☐	Heart attacks or strokes	☐	☐	Cancer
☐	☐	High blood pressure	☐	☐	Breast surgery or problems
☐	☐	Depression	☐	☐	Pelvic infection treated in the hospital
☐	☐	Migraines or bad headaches	☐	☐	Uterine fibroids or Ovarian cysts
☐	☐	Blood clot in your blood vessels like the leg or lung	☐	☐	Eczema or bad skin rashes
☐	☐	Hepatitis (turned yellow) or gallbladder problem	☐	☐	Ectopic or tubal pregnancy
☐	☐	Any other serious medical condition, surgery, or hospitalization	☐	☐	Blood transfusions or IV Drug use

---

Has anyone in your **immediate** family (mother, father, sister, brother, daughter, son, or if your parents are less than 50 give information about other relatives) had any of the following:

		No	Yes
Cancer:	Who, what type and at what age found?	☐	☐
Diabetes:	Who and at what age?	☐	☐
Heart Attack:	Who and at what age?	☐	☐
Stroke:	Who and at what age?	☐	☐
Blood clots in blood vessels like the leg or lung?		☐	☐

Who and at what age? ____________________

Do Not Write Here

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.

Do you use tobacco? ☐ No ☐ Yes How much do you use? ______________ How many years? ________

Do you drink alcohol? ☐ No ☐ Yes How often? ☐ daily ☐ weekly ☐ monthly

How many alcoholic drinks do you have at one time? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine, or IV drugs)? ☐ No ☐ Yes

What do you use? ____________________ How often? ☐ daily ☐ weekly ☐ monthly

Do you feel safe from violence in your personal relationships? ☐ No ☐ Yes

Have you ever had a sexually transmitted disease or genital infection? ☐ No ☐ Yes

Check the ones you might have had: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital Warts ☐ PID ☐ Syphilis ☐ HIV ☐ Bacterial Vaginosis ☐ Trichomonas ☐ Hepatitis B or C ☐ Yeast

History: Female Family Planning

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999 Third Avenue, Suite 900
Seattle, WA 98104
Phone: 206-296-4600
Fax: 206-296-0166

Client Name: ____________________

HR #: ____________________

D.O.B.: ____________________

How many different sex partners have you had in the last 12 months? ____________________

Were your partners (check correct answers): ☐ men ☐ women ☐ both ☐ IV drug users ☐ bisexual
☐ a partner with multiple sex partners or at risk for HIV or STD infection

How long have you been with your current sex partner(s)?______________ Age you first had sex ____________

What type of sex have you had in the past 2 months? (check the types) ☐ Vaginal ☐ Oral ☐ Anal ☐ Other ☐ No Sex

Do you have symptoms of a genital infection? ☐ No ☐ Yes (check the ones you have)
☐ Discharge ☐ Odor ☐ Itch ☐ Rash ☐ Bumps ☐ Sores ☐ Pain with sex ☐ Bleeding after sex
☐ Burning ☐ Stool or anal problems ☐ Pain with urination ☐ Urgent or frequent urination

---

Have you used a birth control method before? ☐ No ☐ Yes (Check the types you have used and write in years of use:)

☐ Pills	☐ Condoms	☐ Diaphragm / Cervical Cap	☐ Implant
☐ IUD	☐ Shot/Depo	☐ Vasectomy/Tubal	☐ Other ____________
☐ Withdrawal	☐ Suppository/Film/Foam	☐ Natural Family Planning/Rhythm	____________
☐ Patch/Ring	☐ Emergency Contraceptive Pills	☐ Abstinence	____________

What do you use now? ____________________

List any problems with your current methods: ____________________

Have you used birth control pills or injections for more than 5 years? ☐ No ☐ Yes
(this can prevent cancer of the ovaries and uterus)

Are you up to date with your immunizations like Rubella or Hepatitis? ☐ No ☐ Yes ☐ Unknown

---

How old were you when you had your first period? Age: __________

For your most recent period, what was the first day bleeding started? Date: ______________

How many days do your periods last? # of days: __________ Do you bleed between periods? ☐ No ☐ Yes

How many days from the start of one period until the start of the next period? # of days: ____________

When was the last time you had sex with a male without birth control? Date: ______________

Do you think you could be pregnant today? ☐ No ☐ Yes

Do you ever douche or use genital deodorant sprays, powders or wipes? ☐ No ☐ Yes

Will this be your first pelvic exam today? ☐ No ☐ Yes Date of your last Pap test: ______________

Have your Pap tests been normal? ☐ No ☐ Yes DES exposure ☐ No ☐ Yes
If you have had an abnormal Pap test, when, where, and what was done? ____________________

Have you ever been pregnant? ☐ No ☐ Yes (If no, you are done) Are you breastfeeding? ☐ No ☐ Yes

# of pregnancies	____________	# of deliveries	____________	# of ectopics	____________
# of living children	____________	# of abortions	____________	# of miscarriages	____________

If you have been pregnant before, when did your last pregnancy end? Date: ______________

When you were pregnant, did you get diabetes? ☐ No ☐ Yes

Have any of your babies been 10 pounds or more? ☐ No ☐ Yes ☐ no babies

History reviewed by: ______________________________ Date:______________

History: Female Family Planning

Public Health
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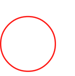
Public Health – Seattle & King County
999 Third Avenue, Suite 900
Seattle, WA 98104
Phone: 206-296-4600
Fax: 206-296-0166

Client Name: ______________________

HR #: ______________________

D.O.B.: ______________

Distribution: **White – Health Records**



Historia Médica de Planificación Familiar Femenina

Female Family Planning Health History

Por favor conteste las preguntas siguientes: *Please answer the questions below:*

Apellido(s): Last Name	**Nombre**: First	**Fecha de nacimiento** Date of Birth	**Edad** Age	**Fecha** Date today

Número de teléfono en su domicilio Home Phone Number	**Mensaje/número de mensáfono** Message / Pager Number	**Mejor hora para llamarle** Best Time to Call
( )	( )	

¿Cuál es la razón principal de su visita el día de hoy?______________________________
What is the main reason for your visit today?

¿Es usted alérgica a algún medicamento, mariscos o al cobre? ☐ No *No* ☐ Si *Yes*
¿A cuáles? y describa cómo es la reacción: ______________________________
Are you allergic to any medicines, shellfish, or copper? Which ones and describe what happened.

¿Toma usted (o supuestamente debe tomar) medicamentos, remedios naturales, aspirina o algún otro medicamento diariamente?
☐ No *No* ☐ Si *Yes* *Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day? List them:*
De ser así, por favor indíquelos. ______________________________

No *No*	**Si** *Yes*	**¿Alguna vez ha tenido o tiene?** *Have you ever had or do you have:*
☐	☐	Diabetes *Diabetes*
☐	☐	Convulsiones *Seizures*
☐	☐	Ataques al corazón o Derrames cerebrales *Heart attacks or Strokes*
☐	☐	Presión sanguínea alta *High blood pressure*
☐	☐	Depresión *Depression*
☐	☐	Migrañas o dolores de cabeza fuertes *Migraines or bad headaches*
☐	☐	Coágulos de sangre en sus vasos sanguíneos como en la pierna o el pulmón *Blood clot in your blood vessels like the leg or lung*
☐	☐	Hepatitis (Piel amarilla) o problemas con la vesícula biliar *Hepatitis (turned yellow) or gallbladder problem*
☐	☐	Transfusiones de sangre o uso de drogas por las venas *Bood transfusions or IV Drug use*
☐	☐	Problemas con los riñones o la vejiga *Problems with your kidneys or bladder*
☐	☐	Enfermedad o debilidad de huesos *Bone disease or weak bones*
☐	☐	Cáncer *Cancer*
☐	☐	Cirugía o problemas con los senos *Breast surgery or problems*
☐	☐	Infecciones pélvicas tratadas en un hospital *Pelvic infection treated in the hospital*
☐	☐	Fibromas uterinos o Quistes en los ovarios *Uterine fibroids or Ovarian cysts*
☐	☐	Eczema o sarpullido fuerte de la piel *Eczema or bad skin rashes*
☐	☐	Embarazos ectópicos o en las trompas de falopio *Ectopic or tubal pregnancy*
☐	☐	Alguna otra enfermedad seria, cirugía u hospitalización *Any other serious medical condition, surgery, or hospitalization*

¿Alguna vez alguien en su familia **CERCANA** (madre, padre, hermana, hermano, hija, hijo, o si sus padres tienen menos de 50 años, dé información acerca de otros familiares) ha tenido algo de lo siguiente?: *Has anyone in your **IMMEDIATE** family (mother, father, sister, brother, daughter, son, or if your parents are less than 50 give information about other relatives) had any of the following:*

		No *No*	**Si** *Yes*	**No Escriba Aqui** *Do not write here*
Diabetes: *Diabetes*	¿Quién y a qué edad? *Who and at what age*	☐	☐	______
Ataques al corazón: *Heart Attack*	¿Quién y a qué edad? *Who and at what age*	☐	☐	______
Cáncer: *Cancer*	¿Quién, qué tipo, y a qué edad fue descubierto? *Who, what type and at what age found*	☐	☐	______
Derrame cerebral: *Stroke*	¿Quién y a qué edad? *Who and at what age*	☐	☐	______
¿Coágulos de sangre en sus vasos sanguíneos como en la pierna o el pulmón? *Blood clots in blood vessels like the leg or lung?*		☐	☐	______

¿Quién y a qué edad? ______________________________
Who and at what age

History: Female Family Planning

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Client Name: ______________________________
HR #: ______________________________
D.O.B.: ______________________

Nuestros servicios son confidenciales, sin embargo, si usted es menor de 18 años y comparte con nosotros historia de abuso sexual o violación nosotros estamos obligados por ley a reportar ésto a los Servicios Protectores de la Niñez. Si usted tiene preguntas acerca de estas leyes, por favor pregunte. *Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.*

¿Utiliza o consume usted tabaco? ☐ No ☐ Si ¿Qué cantidad consume?______________ ¿Hace cuántos años?_________
Do you use tobacco? No Yes How much do you use? How many years?

¿Toma bebidas alcohólicas? ☐ No ☐ Si ¿Con qué frecuencia? ☐ diariamente ☐ semanalmente ☐ mensualmente
Do you drink alcohol? No Yes How often? daily weekly monthly

¿Cuántas bebidas se toma al mismo tiempo? ☐ 1-2 bebidas ☐ 3-4 bebidas ☐ 5+ bebidas
How many alcoholic drinks do you have at one time? 1-2 drinks 3-4 drinks 5+ drinks

¿Consume usted drogas (ejemplo: marihuana , cocaína o drogas por las venas)? ☐ No ☐ Si
Do you use other drugs (examples: marijuana, cocaine, or IV Drugs? No Yes

¿Qué es lo que usa? _________________ ¿Con qué frecuencia? ☐ diariamente ☐ semanalmente ☐ mensualmente
What do you use? How often? daily weekly monthly

¿Se siente usted segura y libre de violencia en sus relaciones personales? ☐ No ☐ Si
Do you feel safe from violence in your personal relationships? No Yes

¿Algúna vez ha tenido una enfermedad transmitida sexualmente o alguna infección genital? ☐ No ☐ Si
Have you ever had a sexually transmitted disease or genital infection? No Yes

Encierre en un círculo aquellas que posiblemente usted haya tenido: *Circle the ones you might have had:*

☐ Clamidia *Chlamydia* ☐ Gonorrea *Gonorrhea* ☐ Herpes *Herpes* ☐ Verrugas genitales *Genital Warts* ☐ Enfermedad inflamatoria pélvica *PID* ☐ Sífilis *Syphilis*

☐ VIH *HIV* ☐ Vaginosis Bacteriana *Baterial Vaginosis* ☐ Tricomonas *Trichomonas* ☐ Hepatitis B o C *Hepatitis B or C* ☐ Infecciones causadas por hongos *Yeast*

¿Cúantas parejas sexuales ha tenido en los últimos 12 meses?________________________________
How many different sex partners have you had in the last 12 months?

Su(s) pareja(s) fueron (encierre en un círculo las respuestas correctas) *Were your partners (check correct answers)*

☐ Hombres *Men* ☐ Mujeres *Women* ☐ Ambos *Both* ☐ Usuarios de drogas por las venas *IV Drug Users* ☐ Bisexual *Bisexual*

☐ Una pareja con múltiples parejas sexuales o con riesgo de VIH o infección por transmisión sexual
A partner with multiple sex partners or at risk for HIV or STD Infection

¿Cúanto tiempo tiene con su(s) pareja(s) actual(es)? ________________________________
How long have you been with your currect partner(s)?

¿Qué tipo de sexo ha tenido en los últimos 2 meses? (encierre en un círculo) ☐ Vaginal ☐ Oral ☐ Anal ☐ Otros ☐ Ninguno
What type of sex have you had in the past 2 months? (check the types) Vaginal Oral Anal Other No Sex

¿Tiene usted síntomas de infección genital? ☐ No ☐ Si (encierre en un círculo los que tenga)
Do you have symptoms of a genital infection? No Yes (check the ones you have)

☐ Desecho vaginal *Discharge* ☐ Olor *Odor* ☐ Comezón (picazón) *Itch* ☐ Sarpullido *Rash* ☐ Bultos *Bumps* ☐ Llagas *Sores* ☐ Dolor al tener relaciones sexuales *Pain with Sex*

☐ Sangrado después de tener relaciones sexuales *Bleeding after sex* ☐ Ardor (quemazón) *Burning* ☐ Problemas con el ano o las heces fecales *Stool or anal problems*

☐ Dolor al orinar *Pain with urination* ☐ Orina frecuentemente o con urgencia *Urgent or frequent urination*

¿Ha usado algún método anticonceptivo anteriormente? ☐ No ☐ Si Encierre en un circulo lo que ha usado y escriba cuantos años lo usó: *(Check the types you have used and write in years of use)*
Have you used a birth control method before? No Yes

☐ Píldoras *Pills* ☐ Condones *Condoms* ☐ Vasectomía/ligadura trompas *Vasectomy / Tubal* ☐ Abstinencia *Abstinence*

☐ Dispositivo *IUD* ☐ Inyeccion / Depo *Shot / Depo* ☐ Diafragma/capuchón cervical *Diaphragm/Cervical cap* ☐ Implantes *Norplant*

☐ Eyacular fuera *Withdrawal* ☐ Supositorio/sello vaginal/espuma *Suppository / Film / Foam* ☐ Píldoras anticonceptivas de emergencia *Emergency contraceptive pills* ☐ Otro ______________ *Other*

☐ Parche/Anillo *Patch / Ring* ☐ Diafragma/capuchón cervical *Diaphragm / cervical cap* ☐ Planificación familiar Natural/Método del Ritmo *Natural Family Planning / Rhythm*

History: Female Family Planning

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¿Qué es lo que utiliza ahora? ____________________
What do you use now?

¿Tiéne algún problema con su método actual? ____________________
List any problems with your current methods

¿Alguna vez ha tomado píldoras anticonceptivas por más de 5 años? ☐ No ☐ Si
(ésto puede prevenir el cáncer de los senos y del útero) *No* *Yes*
Have you used birth control pills for more than 5 years? (this can prevent cancer of the ovaries and uterus)

¿Está usted al día con sus inmunizaciones como la Rubéola o Hepatitis? ☐ No ☐ Si ☐ No recuerdo
Are you up to date with your immunizations like Rubella or Hepatitis? *No* *Yes* *Unknown*

¿Qué edad tenía usted cuando tuvo su primera menstruación? Edad: ____________
How old were you when you had your first period? *Age*

¿En su menstruación más reciente, cuál fue el primer día que comenzó a sangrar? Fecha: ____________
For your mosts recent period, what was the first day bleeding started? *Date*

¿Cuántos días le duran sus menstruaciones? # de días: ____________ ¿Sangra entre reglas? ☐ No ☐ Si
How many days do your periods last? *# of days* *Do you bleed between periods* *No* *Yes*

¿Cuántos días pasan desde el principio de una menstruación hasta el comienzo de la siguiente? # de días: ____________
How many days from the start of one period until the start of the next period? *# of days*

¿Cuándo fue la última vez que tuvo relaciones sexuales con un hombre sin usar ningún método anticonceptivo? Fecha: ____________
When was the last time you had sex with a male without birth control? *Date*

¿Piensa que podría estar embarazada ahora? ☐ No ☐ Si
Do you think you could be pregnant today? *No* *Yes*

¿Se hace lavado vaginal o usa desodorantes vaginales en aerosol, talcos o paños? ☐ No ☐ Si
Do you ever douche or use genital deodorant sprays, powders or wipes? *No* *Yes*

¿Va a ser éste su primer exámen pélvico el día de hoy? ☐ No ☐ Si Fecha de su último Papanicolau: ____________
Will this be your first pelvic exam today? *No* *Yes* *Date of your last Pap test*

¿Han sido sus pruebas de Papanicolau siempre normales? ☐ No ☐ Si ¿Ha estado expuesta a DES? ☐ No ☐ Si
Have your Pap tests been normal? *No* *Yes* *DES exposure* *No* *Yes*

Si alguna vez tuvo una prueba anormal de Papanicolau, diga cuándo, en dónde y qué se hizo al respecto? ____________
If you have had an abnormal Pap test, when, where, and what was done?

¿Ha estado usted embarazada alguna vez? ☐ No ☐ Si (si contestó NO, ha terminado) ¿Está dando pecho? ☐ No ☐ Si
Have you ever been pregnant? *No* *Yes* *(If no, you are done)* *Are you breastfeeding?* *No* *Yes*

de embarazos ____________ # de partos ____________ # de embarazos ectópicos ____________
# of pregnancies *# of deliveries* *# of ectopics*

de hijos vivos ____________ # de abortos inducidos ____________ # de abortos espontáneos ____________
# of living children *# of abortions* *# of miscarriages*

Si usted ha estado embarazada anteriormente ¿cuándo terminó su último embarazo? Fecha: ____________
If you have been pregnant before, when did your last pregnancy end? *Date*

¿Tuvo diabetes cuando usted estaba embarazada? ☐ No ☐ Si
When you were pregnant, di you get diabetes? *No* *Yes*

¿Alguno de sus bebés nació pesando 10 libras o más? ☐ No ☐ Si ☐ ningún bebé
Have any of your babies been 10 pounds or more? *No* *Yes* *No babies*

Notas: *Notes*

____

____

____

____

____

____

Historia revisada por: ____________________ Fecha: ____________
History reviewed by *Date*

History: Female Family Planning

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D.O.B.: ____________________

Distribution: **White – Health Records**

Date of Visit							
Annual Visit	☐	☐	☐	☐	☐	☐	
Ht. / Wt.							
BP							
BC Method							
Laboratory: # Dispensed							
Laboratory: HCT / Hgb	☐	☐	☐	☐	☐	☐	
Laboratory: PAP	☐	☐	☐	☐	☐	☐	
Laboratory: GC	☐	☐	☐	☐	☐	☐	
Laboratory: CT	☐	☐	☐	☐	☐	☐	
Laboratory: RPR	☐	☐	☐	☐	☐	☐	
Laboratory: HIV	☐	☐	☐	☐	☐	☐	
Laboratory: UCG							
Laboratory: LMP							
Laboratory: Other							

Date of Visit							
Annual Visit	☐	☐	☐	☐	☐	☐	
Ht. / Wt.							
BP							
BC Method							
Laboratory: # Dispensed							
Laboratory: HCT / Hgb	☐	☐	☐	☐	☐	☐	
Laboratory: PAP	☐	☐	☐	☐	☐	☐	
Laboratory: GC	☐	☐	☐	☐	☐	☐	
Laboratory: CT	☐	☐	☐	☐	☐	☐	
Laboratory: RPR	☐	☐	☐	☐	☐	☐	
Laboratory: HIV	☐	☐	☐	☐	☐	☐	
Laboratory: UCG							
Laboratory: LMP							
Laboratory: Other							

Date____________ G ______________ P_______________ SAB____________ TAB ______________ Living Children __________

Date____________ G ______________ P_______________ SAB____________ TAB ______________ Living Children __________

Date____________ G ______________ P_______________ SAB____________ TAB ______________ Living Children __________

Flow Sheet: Family Planning

Public Health
Seattle & King County

Public Health – Seattle & King County
401 Fifth Avenue, Suite 1000
Seattle, WA 98104
Phone: 206-263-8354
Fax: 206-205-6236

Form #: PH-0075 (Rev. 10/07)

Client Name: ______________________________________

HR #: ____

D.O.B.: ______________________

Inventory #: 450-0319

Distribution: **White – Health Records**

IUD Insertion Procedure Chart Form

Age: ______ G: ________ P: ________ LMP: ________ ≤ Day 7 of cycle ❑Yes ❑No Cycle Day: ________
Date of last delivery: _______________ C-Section Hx? ❑ Yes ❑ No Lactation: ❑ Yes ❑ No
Next child wanted in how many years? ______, or No more children wanted at this time ❑Prior use of IUD: ❑No ❑Yes
❑ No concerns about pregnancy today ❑ Wants the T380 A IUD as an EC because:______________________________
Single current partner of what duration: ________years ________months Current Contraception: ________________
Reason for choosing IUD over other BCM:

- ❑ If unprotected intercourse in last 5 days understands it is an EC and accepts the risk of pregnancy ❑ N/A
- ❑ Counseled about both copper and Lng systems and chooses: _______________
- ❑ Has documented Pap/breast exam within past 12 months
- ❑ No copper, betadine, lidocaine, silicone, polyethylene or Lng allergy
- ❑ No contraindications to the method
- ❑ Completed and/or reviewed IUD manufacturer's brochure and/or consent form.
- ❑ PHSKC FP Consent for Treatment Form signed and placed in chart
- ❑ Chart labeled with Do Not Discard sticker
- ❑ Given and confirms reading IUD manufacturer's brochure ❑ Checklist reviewed and no contraindications

Counseling/Evaluation:
- ❑ Items reviewed
- ❑ See progress note

Accepts risk of
- ❑ 1/200 failure the first year and 2% over the life of the IUD.
- ❑ expulsion risk 5%, 90% symptomatic but 10% none, so important to check for strings after menses.
- ❑ 1/100 risk of PID from the insertion and 2-5% risk IUD later removed for possible infection.
- ❑ ectopic pregnancy if failure (30% risk). History of ectopic ❑ No ❑ Yes, signed additional consent
- ❑ dysmenorrhea, menorrhagia or anemia if T380A ❑ amenorrhea or irregular bleeding if Lng IUD
- ❑ possible risk of PID if STD contracted
- ❑ possible 50% chance of SAB if intrauterine pregnancy with IUD in place, and also risk of SAB with removal

Screening tests negative for following tests: ❑ CT (date______) ❑ GC (date______) ❑ Pap (date______)
(if appropriate) ❑ BV (date______) ❑ HCG (date______) ❑ hct/hgb (year_______)

Procedure Note Premedication: ______________
Bimanual exam results: ❑ AV/AF ❑ midline ❑ RV/RF ❑ small, firm, non-pregnant, symmetric ❑ other: ____________
Cervical os cleaned with: ❑ betadine ❑ chlorhexidine ❑ BP________ ❑ Pulse________
Tenaculum placed on cervix: ❑ Anterior ❑ Posterior
Sounded depth: ❑ 6.0 cm ❑ 6.5 cm ❑ 7.0 cm ❑ 7.5 cm ❑ 8.0 cm ❑ 8.5 cm ❑ 9.0 cm ❑ Other: ___________
Type of IUD: ❑ T380A ❑ Lng 20mcg ❑ other: _______________ Lot # _____________ Expiration ___________

- ❑ IUD placed at fundus easily without complications
- ❑ Strings cut to ______ inch length. Client felt cut pieces and taught to feel for strings
- ❑ Tolerated procedure well
- ❑ No complications, or ____
- ❑ Given advice to: call for fever, excess bleeding, missed menses, pain, or if IUD strings not felt.
- ❑ Advised: no vaginal penetration for 3 to 7 days, backup method for 1 week if not on menses, return to clinic in 6 weeks for exam and sooner if needed for a pregnancy test especially if IUD inserted as an EC method.
- ❑ Reminded to return every year for an annual exam.
- ❑ Advised of the date that the device will no longer be effective: __________________________

NOTES:
❑ Interpreter present and assisted with visit

____
MA\RN Provider Signature/Title Date

Place Patient Information Sticker Here

MONTHLY INJECTABLE (LUNELLE) CONTRACEPTIVE FLOW SHEET

Date of Last Annual Exam	LMP	BP	WT	Probs. (Y / N)	See Prog. Note? (Y / N)	Today's Injection	Plan
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:___________________________	Next Due:_________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:___________________________	Next Due:_________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:___________________________	Next Due:_________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:___________________________	Next Due:_________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:___________________________	Next Due:_________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:___________________________	Next Due:_________
Date:			Signature:				
						❑ See Med sheet for Lot # / Exp date Lunelle: 25 mg MPA/5 mg EC IM ❑ Site:___________________________	Next Due:_________
Date:			Signature:				

Place Patient Information Sticker Here
OR Name & DOB

Male Family Planning / STD Visit

Please answer all questions below: ***(Do not urinate before exam!)***

Last Name	First	Age	Who do you live with
Home Phone Number	Message / Pager Number		Best Time to Call

What is the main reason for your visit today? ______

Are you allergic to any medicines? ☐ Yes ☐ No

Which ones and describe what happened: ______

Do you take medicines, natural remedies, aspirin, or other drugs every day? ☐ Yes ☐ No

List them: ______

Are you up to date with your immunizations, like Rubella and Hepatitis B? ☐ Yes ☐ No ☐ Unknown

Do you use tobacco? ☐ Yes ☐ No How much do you use? ______ How many years? ______

Do you drink alcohol? ☐ Yes ☐ No How often? ☐ Daily ☐ Weekly ☐ Monthly

How many alcoholic drinks do you have? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine or IV drugs)? ☐ Yes ☐ No

What do you use? ______ How often? ☐ Daily ☐ Weekly ☐ Monthly

Have you ever had or do you have: High blood pressure .... ☐ Yes ☐ No Hepatitis (turned yellow) .... ☐ Yes ☐ No

IV drug use .... ☐ Yes ☐ No Problems with your kidneys or bladder ... ☐ Yes ☐ No

Any other serious medical condition… ☐ Yes ☐ No

Have you ever had a sexually transmitted disease or genital infection? ☐ Yes ☐ No

(check the ones you think you might have had) ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital Warts ☐ Syphilis ☐ HIV ☐ Jock Itch ☐ Hepatitis B or C

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape, we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.

How many different sex partners have you had in the last 12 months? ______

Were your partners (check): ☐ women ☐ men ☐ both ☐ IV drug user ☐ bisexual ☐ a partner with multiple sex partners or at risk for HIV or STD

How long have you been with your current sex partner(s)? ______

What type of sex have you had in the past 2 months (check): ☐ Vaginal ☐ Oral ☐ Anal ☐ Other ☐ No sex

Are you and your current sex partner(s) using a birth control method (if any of your sex partners are female)?

If so, what kind? ______

Do you have symptoms of a genital infection? ☐ Yes ☐ No (check the ones you have)

☐ Rash ☐ Itch / Pain ☐ Pain with urination ☐ Urgent or frequent urination ☐ Stool or anal problems

☐ Bumps ☐ Burning ☐ Sores ☐ Drip / Discharge ☐ Rectal bleeding

Have you had sexual contact with a person with a positive STD test? ☐ No ☐ Yes

Have you had a positive STD test in the last year? ☐ No ☐ Yes

Date of your last sexual contact? ______ **Did you use a condom**? ☐ Yes ☐ No

Have you used condoms before? ☐ Yes ☐ No

How many hours since you last urinated? ______

Reviewed by ______ Date: ______

Visit: Male Family Planning / STD

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401 5th Ave. Suite #1000
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236

Client Name: ______

HR #: ______

D.O.B.: ______

Housing Status: ____________________

CC: ____________________

ROS: ☐ Constitutional ☐ Skin ☐ GI ☐ GU ☐ Breast ☐ Neuro ☐ CV ☐ Resp ☐ Ent ☐ Eyes ☐ Musculoskeletal

PMH / SH / FH: (negative if checked, unless specified)

HPI:

☐ HIV testing requested for client .... ☐ Client agrees
☐ HIV testing recommended for client ..... ☐ Client agrees

BP __________ WT __________ HT __________

	NL	ABNL	N/A
Skin	☐	☐	☐
Lungs	☐	☐	☐
Heart	☐	☐	☐
Abdomen	☐	☐	☐
Groin lymph nodes	☐	☐	☐
Urethral discharge	☐	☐	☐
Penis shaft	☐	☐	☐
Penis glands	☐	☐	☐
Scrotum	☐	☐	☐
Inguinal canal	☐	☐	☐
Testes descended	☐	☐	☐
Rectal exam	☐	☐	☐
Anal area	☐	☐	☐

Stat Tests Done:

☐ UA dip: LE __________ Nitrate __________
Prot __________ Blood __________
Other ____________________

Education: ☐ ECRR ☐ Testicular self exam
Smoking: ☐ advised to quit/congratulated ☐ Hep B
☐ Partner treatment ☐ Partner's contraceptive method
☐ Condom use ☐ Contraception ☐ STD HIV Prevention
☐ Abstinence ☐ ECP ☐ Other

Literature Given: ☐ Smoking ☐ HIV ☐ STD's ☐ Condoms

Other: ____________________

Assessment:

Tests Sent: ☐ CT ☐ GC ☐ HSV ☐ HIV
☐ RPR ☐ Hep B ☐ Hep C

Plan:

Check medications prescribed:

1. ☐ Condoms: __________ # given
2. ☐ Azithromycin ...... 1 gm PO
3. ☐ Ceftriaxone .... 125 mg 1M given
4. ☐ Cefpodoxime ...... 200 mg #2 PO
5. ☐ Doxycycline .... 100 mg 1 PO BID x 7 days
6. ☐ Metronidazole .... 500 mg 4 PO once
7. ☐ Acyclovir .... 400 mg 1 PO TID x _______ days
8. ☐ Hep B vaccine injection site ________ lot #
9. ☐ Other:

Signature ______________________________ Date ______________

Visit: Male Family Planning / STD

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
401 5th Ave. Suite #1000
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236

Client Name: ____________________

HR #: ____________________

D.O.B.: ____________________

Distribution: **White – Health Records**

Master Problem List

Date / Initial	Active Problems	Outcome / Date(s)
	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
	7.	
	8.	
	9.	
	10.	

Initials	Signature	Signature	Initials

Alert / Allergies:

Problem List: Master

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Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
401 5th Ave. Suite #1000
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236

Client Name: ______________________

HR #: ______________________

D.O.B.: ______________

PH-0109 (Rev. 9/07) 450-0249 1202M

Distribution: **White – Health Records**

MEDICATION LIST

Date	Drug Name, Dose, Quantity (Put Sticker Here)	Route, Frequency	Signature
------------	--	-----------------------	----------------------------
------------	--	-----------------------	----------------------------
------------	--	-----------------------	----------------------------
------------	--	-----------------------	----------------------------
------------	--	-----------------------	----------------------------
------------	--	-----------------------	----------------------------
------------	--	-----------------------	----------------------------

Allergy Sticker Here

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here

Date	**Drug Name, Dose, Quantity** (Put Sticker Here)	**Route,** **Frequency**	**Signature**

Pregnancy Screening

Age: ________ Gravida: ________ Para: ________ SAB: ________ TAB: ________ Living children: ________

LMP: ________ LNMP: ________ Date last pregnancy ended: ________ Last Pap: ________

Last BCM used : ________ Last UPIC: ________ Breastfeeding: ☐ Yes ☐ No

Complications with previous pregnancies: ________

Allergies: ________ Daily medications taken: ________

Serious medical problems: ________

Pregnancy Sx present? ________ Genital infection Sx present? ________

Ectopic risk factors? ________ STD risk factors? ________

UCG: ☐ positive ☐ negative Planned Pregnancy? ☐ Yes ☐ No Pregnancy Options Discussed? ☐ Yes ☐ No

Discussed decision/plans: ________

____

Referrals: ☐ Abortion Facility ☐ DSHS / Application Worker ☐ EC Rx
☐ Family Planning ☐ Hospital / ER ☐ Maternity Screening / Support Services
☐ PHN ☐ PMD ☐ Provider Visit in Clinic Today
☐ Social Worker ☐ WIC ☐ Other : ________

Assess as appropriate: Provide Counseling/Education, depending on decision **(check box if done)**

☐ Obstetric care services ☐ Hot tubs, saunas ☐ Substance use / medications ☐ Smoking
☐ Abortion services ☐ Rubella, Hep B, other ☐ Domestic Violence ☐ X-rays
☐ Adoption services ☐ Alcohol ☐ Animals in household

Vitamins with folate ☐ discussed ☐ given ☐ prescription ________

Handouts: ☐ No ☐ Yes ________

Signature: ________ Date ________

Exam: Uterus size: ________ BP: ________ Pulse: ________ Weight: ________

Abdominal Exam: ________

Tests: ☐ CT ☐ GC ☐ Pap ☐ Wet mount: BV ________ trich ________ yeast ________

Notes: ________

____

____

Signature: ________ Date: ________

Public Health – Seattle & King County Verification of Pregnancy

________ was seen on ________
(Name) (Date)

The presence of a pregnancy of ________ menstrual weeks gestation is presumed on the basis of the following:

Last Menses (LMP): ________ Pregnancy test (UCG) ☐ positive EDD: ________

Please start Medicaid coverage as of ________ First Steps referral on ________

Signature: ________ Date: ________

Screening: Pregnancy

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
999 Third Avenue, Suite 900
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236

Client Name: ________

HR #: ________

D.O.B.: ________

Distribution: **White – Health Records** Yellow – Provider Copy White – CSO/Client Copy

Pregnancy Screening

Age: ________ Gravida: ________ Para: ________ SAB: ________ TAB: ________ Living children: ________________

LMP: ____________ LNMP: ____________ Date last pregnancy ended: ______________ Last Pap: ____________

Last BCM used : ______________________________ Last UPIC: ____________ Breastfeeding: ☐ Yes ☐ No

Complications with previous pregnancies: ____

Allergies: ____________________________________ Daily medications taken: ____________________________

Serious medical problems: ____

Pregnancy Sx present? ____________________________ Genital infection Sx present? ________________________

Ectopic risk factors? __________________________ STD risk factors? ______________________________________

UCG: ☐ positive ☐ negative Planned Pregnancy? ☐ Yes ☐ No Pregnancy Options Discussed? ☐ Yes ☐ No

Discussed decision/plans: ____

____

Referrals:

☐ Abortion Facility	☐ DSHS / Application Worker	☐ EC Rx
☐ Family Planning	☐ Hospital / ER	☐ Maternity Screening / Support Services
☐ PHN	☐ PMD	☐ Provider Visit in Clinic Today
☐ Social Worker	☐ WIC	☐ Other : ____________________

Assess as appropriate: Provide Counseling/Education, depending on decision **(check box if done)**

☐ Obstetric care services	☐ Hot tubs, saunas	☐ Substance use / medications	☐ Smoking
☐ Abortion services	☐ Rubella, Hep B, other	☐ Domestic Violence	☐ X-rays
☐ Adoption services	☐ Alcohol	☐ Animals in household	

Vitamins with folate ☐ discussed ☐ given ☐ prescription ________________________________

Handouts: ☐ No ☐ Yes ____

Signature: ____ Date ____________________

Exam: Uterus size: ____________________ BP: ________ Pulse: __________ Weight: ____________

Abdominal Exam: ____

Tests: ☐ CT ☐ GC ☐ Pap ☐ Wet mount: BV __________ trich __________ yeast __________

Notes: ____

____

____

Signature: ____ Date: ________________

Public Health – Seattle & King County Verification of Pregnancy

____ was seen on ____________________
(Name) (Date)

The presence of a pregnancy of ____________ menstrual weeks gestation is presumed on the basis of the following:

Last Menses (LMP): __________ Pregnancy test (UCG) ☐ positive EDD: ____________________

Please start Medicaid coverage as of ____________________ First Steps referral on ________________

Signature: ____ Date: __________________________

Screening: Pregnancy

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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Phone: 206-205-5819
Fax: 206-205-6236

Client Name: ______________________________

HR #: ______________________________

D.O.B.: ____________________

Distribution: **White – Health Records** Yellow – Provider Copy White – CSO/Client Copy

Pregnancy test done at: (Provider please check below)

If you had a pregnancy test at any of these Public Health Centers and you want to apply for pregnancy medical coupons, please call the application worker listed with your clinic.

☐ **Auburn Public Health Center**
20 Auburn Avenue
Auburn, WA 98002
206-296-8400 (Main)
206-205-6878 (Application Worker)
206-205-6889 (Application Worker)

☐ **Columbia Public Health Center**
4400 37th Avenue South
Seattle, WA 98118
206-296-4650 (Main)
206-205-6039 (Application Worker)
206-205-6096 (Application Worker)

☐ **Downtown Public Health Center**
2124 Fourth Avenue
Seattle, WA 98121
206-296-4755 (Main)
206-205-9137 (Application Worker)

☐ **Eastgate Public Health Center**
14350 Southeast Eastgate Way
Bellevue, WA 98007
206-296-4920 (Main)
206-296-9781 (Application Worker)
206-205-8979 (Application Worker)

☐ **Federal Way Public Health Center**
33431 13th Place South
Federal Way, WA 98003
206-296-8410 (Main)
206-296-9881 (Application Worker)

☐ **Kent Public Health Center**
1404 South Central Avenue
Suite 112, Kent, WA 98032
206-296-4500 (Main)
206-205-1936 (Application Worker)

☐ **Kent Teen Clinic**
233 2nd Ave S.
Kent, WA 98032
206-296-7450 (Main)
206-205-1936 (Application Worker)

☐ **North Public Health Center**
10501 Meridian Avenue North
Seattle, WA 98133
206-296-4765 (Main)
206-205-6944 (Application Worker)
206-205-9132 (Application Worker)

☐ **Northshore Public Health Center**
10808 Northeast 145th Street
Bothell, WA 98011
206-296-9787 (Main)
206-296-9800 (Application Worker)

☐ **Renton Public Health Center**
3001 Northeast Fourth
Renton, WA 98056
206-296-4700 (Main)
206-205-1700 (Application Worker)

☐ **White Center Public Health Center**
10821 Eighth Avenue Southwest
Seattle, WA 98146
206-296-4620 (Main)
206-205-7242 (Application Worker)

DSHS Offices

☐ **Belltown**
2106 Second Avenue
Seattle, WA 98101
206-239-3633 (Main)
206-239-3664 (Nurse)

☐ **Capitol Hill**
1700 East Cherry
Seattle, WA 98122
206-568-5500 (Main)
206-568-5531 (Nurse)

☐ **Federal Way**
616 South 348th Street
Federal Way, WA 98063
253-835-2800 (Main)
253-835-2829 (Nurse)

☐ **King Eastside**
14360 SE Eastgate Way
Bellevue, WA 98007
425-649-4000 (Main)
425-649-4373 (Nurse)

☐ **King North**
907 Northwest Ballard Way
Seattle, WA 98107
206-789-5200 (Main)
206-545-7782 (Nurse)

☐ **King South**
1313 West Meeker Street
Kent, WA 98035
253-341-7429 (Main)
253-372-5886 (Nurse)

☐ **Rainier**
3600 South Graham Street
Seattle, WA 98118
206-760-2000 (Main)
206-760-2314 (Nurse)

☐ **Renton**
500 Southwest 7th Street, #B
Renton, WA 98055
425-793-5700 (Main)
425-793-5777 (Nurse)

☐ **White Center**
9650 15th Avenue SW
Seattle, WA 98106
206-341-7430 (Main)
206-716-2344 (Nurse)

Screening: Pregnancy

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
999 Third Avenue, Suite 900
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236

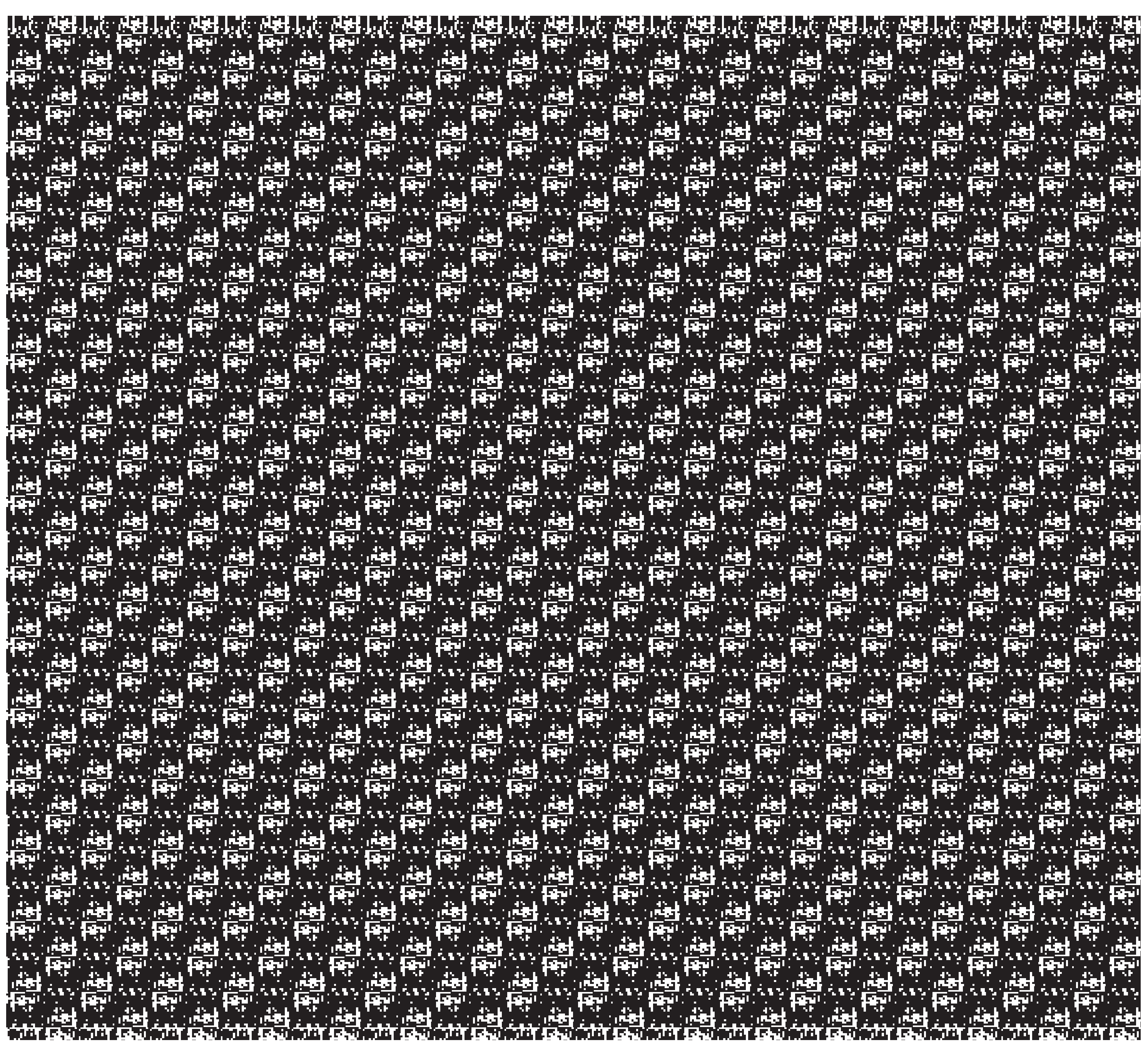
Client Name: ______________________

HR #: ______________________

D.O.B.: ______________

Distribution: **White – Health Records** Yellow – Provider Copy White – CSO/Client Copy

Pregnancy Screening



Public Health – Seattle & King County Verification of Pregnancy

______________________________ was seen on ______________________
(Name) (Date)

The presence of a pregnancy of ____________ menstrual weeks gestation is presumed on the basis of the following:

Last Menses (LMP): __________ Pregnancy test (UCG) ☐ positive EDD: ____________________

Please start Medicaid coverage as of ____________________ First Steps referral on ____________________

Signature:______________________________ Date: ____________________

Screening: Pregnancy

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
999 Third Avenue, Suite 900
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236

Client Name: ______________________________

HR #: ______________________________

D.O.B.: ____________________

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Renton, WA 98056
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14360 SE Eastgate Way
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3600 South Graham Street
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206-760-2000 (Main)
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500 Southwest 7th Street, #B
Renton, WA 98055
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9650 15th Avenue SW
Seattle, WA 98106
206-341-7430 (Main)
206-716-2344 (Nurse)

Screening: Pregnancy

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
999 Third Avenue, Suite 900
Seattle, WA 98104
Phone: 206-205-5819
Fax: 206-205-6236

Client Name: ____________________

HR #: ____________________

D.O.B.: ____________

Distribution: **White – Health Records** Yellow – Provider Copy White – CSO/Client Copy

Date	Progress Note	Signature & Title

Progress Notes

Public Health
Seattle & King County

Public Health – Seattle & King County
401 Fifth Avenue, Suite 1000
Seattle, WA 98104
Phone: 206-263-8414
Fax: 206-205-6236

Form #: PH-0074 (Rev. 10/07)

1202M

Client Name: ______________________________

HR #: ______________________________

D.O.B.: ____________________

Inventory #: 450-0248

Distribution: **White – Health Records**

Date	Progress Note	Signature & Title

Progress Notes

Public Health
Seattle & King County

Public Health – Seattle & King County
401 Fifth Avenue, Suite 1000
Seattle, WA 98104
Phone: 206-263-8414
Fax: 206-205-6236

Client Name: ______________________________

HR #: ______________________________

D.O.B.: ____________________

Distribution: **White – Health Records**

Reproductive Health Access Report

The Reproductive Health Access Report is to document instances in which women have difficulty accessing Family Planning Services. This project could help accurately describe and help fix barriers to reproductive health care. You can help by submitting a report whenever a client tells you she experienced difficulty getting the services she wanted or needed. The data collected may be shared with the State Insurance Commissioner about roadblocks to women receiving reproductive health services.

Name of clinic: ____ Date: ____________________________

Name of person completing this form: ______________________________Telephone #: ______________________

Type of reproductive health care sought by client:

❒ Abortion ❒ Sterilization ❒ Pregnancy Screening ❒ Other: ____________________
❒ Family Planning: ❒ DMPA injection ❒ OCPs ❒ Other: ____________________

Information/Referral/Services were refused by: ____

Clients Type of Coverage, if known: ❒ ERISA Plan (employer is self insured) ❒ Basic Health Plan
❒ Healthy Options ❒ DSHS ❒ BHP Plus ❒ Take Charge ❒ Private: ______________________

Client's Health Benefit Company and Plan, or Clinic, or Provider (include name and address):

____

With whom did she/you speak? ____

Please provide a detailed description of the woman's experience when attempting to obtain information or a referral for reproductive health services. Describe access problem. Provide dates and details, what brought her to your clinic, and/or how she was unable to obtain reproductive health services.

____

____

____

What other sources of help were sought?

____

❒ I cannot or do not want to be identified by name or contacted in any form. Please make this an anonymous report.

❒ I understand that this information could be shared with the PHSKC Family Planning Program, the state insurance commissioner, or my health insurance company, and I may be contacted by someone who may try and help fix the problem.

____
Name Date

____
Address Phone #1 Phone #2

Please complete the form below and send to Maria Wood; Clinical Services, Family Planning Program; 401 5th Ave, Suite#1000, Seattle WA, 98104. We will keep a record of the event and if appropriate, forward to the state insurance commissioner's office and/or possibly contact the woman to try and resolve the problem.

Reproductive Health Access Report

Public Health
Seattle & King County

Family Planning Program
Public Health – Seattle & King County
401 Fifth Avenue, Suite 1300
Seattle, WA 98104
Phone: 206-296-4600
Fax: 206-296-0166

Client Name: ____

HR #: ____

D.O.B.: ______________________

Sở Y Tế Công Cộng Seattle & Quận King
Chương Trình Kế Hoạch Gia Đình

Thân Chủ Ưng Thuận Dùng Thuốc Viên Ngừa Thai Khẩn Cấp (ECP) bằng Chỉ Thị Thường Trực

Khi ký tên dưới đây, tôi cho thấy rằng tôi hiểu các thông tin sau đây về ngừa thai khẩn cấp bằng kích thích tố:

- Xác suất tôi mang thai sau khi giao hợp không phòng ngừa là khoảng 1 phần 12. Thuốc Viên Ngừa Thai Khẩn Cấp (ECP) có thể giảm xác suất này xuống còn khoảng 1 phần 50. Tôi biết rằng không thể bảo đảm là tôi sẽ không mang thai và tôi không bắt PHSKC phải chịu trách nhiệm nếu tôi mang thai.
- ECP càng dễ có hiệu quả hơn khi dùng càng sớm càng tốt sau khi giao hợp không phòng ngừa. Tôi càng dùng thuốc sớm bao nhiêu thì càng có hiệu quả bấy nhiêu. Nếu tôi quyết định dùng thử ECP sau 5 ngày, tôi hiểu rằng cơ hội để thuốc có tác dụng bị giảm đi nhiều.
- ECP tác động như thuốc viên ngừa thai, nhưng với liều lượng mạnh hơn. ECP ngừa thai bằng cách ngăn chặn trứng rụng (trứng). ECP không phải là thuốc phá thai và nếu quý vị đã có thai thì thuốc này sẽ không có hiệu quả.
- Tôi có thể cảm thấy buồn nôn hoặc thậm chí ói mửa khi dùng thuốc này.
- Các phản ứng phụ khác của ECP có thể gồm: ra máu, đau bụng dưới, đau vú, nhức đầu, chóng mặt và mệt mỏi.
- Tôi có thể sẽ có kinh vào lần tới trong vòng một tuần trước hoặc sau ngày dự liệu có kinh. Nếu tôi không có kinh sau 3 tuần kể từ khi uống ECP thì tôi biết là tôi có thể có thai và tôi cần trở lại để thử thai.
- Nếu ECP không có hiệu quả thì tôi biết rằng tôi có thể có thai và trường hợp này có thể là mang thai ngoài tử cung hoặc có thai trong vòi trứng tuy rất hiếm khi xảy ra và có thể đe dọa đến mạng sống.
- ECP không ngừa thai được nếu giao hợp không phòng ngừa sau khi dùng ECP. Tôi nên dùng một phương pháp ngừa thai khác sau khi dùng ECP.
- ECP không bảo vệ tôi khỏi những căn bệnh phong tình (STD), kể cả HIV.
- ECP được biết là không tác hại đến thai nhi nếu vô ý dùng thuốc này khi mới có thai.
- Tôi nên xin tái khám nếu tôi cần ngừa thai liên tục hoặc cần chăm sóc kế hoạch gia đình, bị chậm kỳ kinh kế tiếp hơn một tuần, nghi ngờ tôi có thể có thai, hoặc có các lý do quan ngại khác.

Tôi đã có cơ hội nêu thắc mắc và được giải đáp thỏa đáng. Tôi theo đây ưng thuận dùng thuốc viên ngừa thai khẩn cấp bằng kích thích tố (ECP) do PHSKC cung cấp.

______________________________ ____
Ngày | Chữ Ký Bệnh Nhân

______________________________ ____
Nhân Chứng | Thông Dịch Viên

Place Patient Information Sticker Here
OR Name & DOB

Public Health Seattle & King County
Family Planning Program

Client Consent for Emergency Contraception Pills (ECP) by Standing Order

By my signature below, I am indicating that I understand the following information about emergency hormonal contraception:

- My chances of pregnancy following unprotected intercourse are about 1 in 12. Emergency Contraception Pills (ECP) can reduce this risk down to about 1 in 50. I realize that I am not guaranteed that I will not get pregnant and I will hold PHSKC harmless if that occurs.
- ECPs work better the sooner they are taken after unprotected intercourse. The earlier I take the pills, the more effective they will be. If I decide to try ECPs beyond 5 days, I understand the chance of working is a lot less.
- ECPs work like birth control pills, except they are a stronger dose. ECPs prevent pregnancy by blocking ovulation (an egg). ECPs are not an abortion pill and if you are already pregnant they will not work.
- I may have some nausea or even vomiting with this medication.
- Other possible side effects of ECPs include: bleeding, abdominal pain, breast tenderness, headache, dizziness and fatigue.
- I will probably have my next menstrual period within one week before or after the expected time for my period. If I do not have bleeding by 3 weeks from taking the ECP I know I could be pregnant and I will need to return for a pregnancy test.
- If the ECP does not work I know I could be pregnant and very rarely this can be an ectopic or tubal pregnancy and this could be life threatening.
- ECPs do not prevent pregnancy from unprotected sex occurring after the ECP. I should use another form of birth control after using ECP.
- ECPs do not protect me against sexually transmitted diseases (STDs), including HIV.
- ECPs are not known to cause damage to the fetus if used accidentally during early pregnancy.
- I should seek follow-up care if I need ongoing birth control or family planning care, have a delay in my next period of more than one week, suspect that I may be pregnant, or have other reasons for concern.

I have had an opportunity to ask questions and have them answered to my satisfaction. I hereby consent to receiving emergency hormonal contraception (ECP) pills administered by PHSKC.

_______________________	_______________________
Date	Signature of Patient
_______________________	_______________________
Witness	Interpreter

Place Patient Information Sticker Here
OR Name & DOB

Allergy Alert

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Allergy Alert

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Last updated: 08/12/03

CLIA Temperature Log

Site: ___________________________ Month:_____________ Year:___________

Date:	Refrigerator (degrees celcius)	Refrigerator (degrees celcius)	Incubator (degrees celcius)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
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25			
26			
27			
28			
29			
30			
31			

Record the temperature daily when clinic open and keep this record available for accreditation for 2 years. The refrigerator should be kept between 6-8ºc. The incubator should be set at 35ºc, maintain a range of 34-37ºc and keep a cup of water in incubator for moisture.

Reviewed by: ____ Date:______________

Last updated: 6/25/01

Colposcopy Log

Date	Name	Age	GxPx	Referral Pap Test	Colposcopic Impression	Colposcopy Adequacy	Colpo Pap	Biopsy Results	ECC Results	Management	Follow Up Result

Family Planning Program Lab Test Tracking Log

Client Name/ID Number	Collect initials/ date	Ins Info	TEST ORDERED									Lab Sticker
		❑Yes ❑No	**PAP** ❑ Abnl ❑ NL	**CT** ❑ Pos ❑ Neg	**GC** ❑ Pos ❑ Neg	**RPR** ❑ Pos ❑ Neg	**HIV** ❑ Pos ❑ Neg	**HSV** ❑ Pos ❑ Neg	**HCG** ❑ Pos ❑ Neg	**Hct/Hgb**	**Other**	
Results Received date and initials:												
		❑Yes ❑ No	**PAP** ❑ Abnl ❑ NL	**CT** ❑ Pos ❑ Neg	**GC** ❑ Pos ❑ Neg	**RPR** ❑ Pos ❑ Neg	**HIV** ❑ Pos ❑ Neg	**HSV** ❑ Pos ❑ Neg	**HCG** ❑ Pos ❑ Neg	**Hct/Hgb**	**Other**	
Results Received date and initials:												
		❑Yes ❑ No	**PAP** ❑ Abnl ❑ NL	**CT** ❑ Pos ❑ Neg	**GC** ❑ Pos ❑ Neg	**RPR** ❑ Pos ❑ Neg	**HIV** ❑ Pos ❑ Neg	**HSV** ❑ Pos ❑ Neg	**HCG** ❑ Pos ❑ Neg	**Hct/Hgb**	**Other**	
Results Received date and initials:												
		❑Yes ❑ No	**PAP** ❑ Abnl ❑ NL	**CT** ❑ Pos ❑ Neg	**GC** ❑ Pos ❑ Neg	**RPR** ❑ Pos ❑ Neg	**HIV** ❑ Pos ❑ Neg	**HSV** ❑ Pos ❑ Neg	**HCG** ❑ Pos ❑ Neg	**Hct/Hgb**	**Other**	
Results Received date and initials:												

Copy double-sided with 3 hole punch at the top of the title. Keep log sheets for 3 years, then shred.

Last updated: 04/05

PHSKC Family Planning Medication Dispensing Log

Clinic Site: ____________________

<u>Date</u> Initials	**Drug Name, Dose, Qty, Manufacturer, Lot, Exp** (place medication label here)	**Patient Name, PHSKC ID #** (place patient label here)

Last Update: 8.25.04

Pharmacy Implant & Intrauterine System Log

(Keep for 15 years)

Patient Information	Date of Service	Type of Device	Lot #	Expiration Date
Patient Name: Client #: DOB:		❑ T380 A ❑ LNG IUS ❑ Norplant ❑ Implanon		
Patient Name: Client #: DOB:		❑ T380 A ❑ LNG IUS ❑ Norplant ❑ Implanon		
Patient Name: Client #: DOB:		❑ T380 A ❑ LNG IUS ❑ Norplant ❑ Implanon		
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Patient Name: Client #: DOB:		❑ T380 A ❑ LNG IUS ❑ Norplant ❑ Implanon		
Patient Name: Client #: DOB:		❑ T380 A ❑ LNG IUS ❑ Norplant ❑ Implanon		

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Encounter # ________

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Stocking

Stock no more than ________ units in this box and no fewer than _________ units.

Urine Dip Results Sticker

Last updated: 6/28/01

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

BLOOD	BILIRUBIN	UROBILINOGEN	KETONES	GLUCOSE	PROTEIN	NITRITE	LEUKOCYTES	pH	SPEC. GRAVITY
Neg Tr -50 -250	Neg + ++ +++	Normal 1 4 8 12	Neg Sml Mod Lrg	Normal 50 100 150 500 1000l	Neg Tr 30 100 500	Neg Pos	Neg Tr + ++	5 6 7 8 9	1.000 1.005 1.010 1.015 1.020 1.025 1.030

DO NOT PURGE

IUD: ρ T380A ρ LngIUS

Date____________________

Implant: ρ Norplant ρ Implanon

Date____________________

Other: ______________________________

DO NOT PURGE

IUD: ρ T380A ρ LngIUS

Date____________________

Implant: ρ Norplant ρ Implanon

Date____________________

Other: ______________________________

DO NOT PURGE

IUD: ρ T380A ρ LngIUS

Date____________________

Implant: ρ Norplant ρ Implanon

Date____________________

Other: ______________________________

DO NOT PURGE

IUD: ρ T380A ρ LngIUS

Date____________________

Implant: ρ Norplant ρ Implanon

Date____________________

Other: ______________________________

DO NOT PURGE

IUD: ρ T380A ρ LngIUS

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Implant: ρ Norplant ρ Implanon

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DO NOT PURGE

IUD: ρ T380A ρ LngIUS

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DO NOT PURGE

IUD: ρ T380A ρ LngIUS

Date____________________

Implant: ρ Norplant ρ Implanon

Date____________________

Other: ______________________________

DO NOT PURGE

IUD: ρ T380A ρ LngIUS

Date____________________

Implant: ρ Norplant ρ Implanon

Date____________________

Other: ______________________________

Date ______________

Dear ______________________________:

You had a ☐ pap test ☐ colposcopy on_______________.

Your result from that test was ______________________________.

These results indicate that you need either a repeat pap test or further evaluation or possible treatment of your cervix. Abnormal pap testing can mean that you are at risk for cervical cancer and if you do not follow up you may risk developing cervical cancer. Cervical cancer if untreated can lead to hysterectomy and or death. We are enclosing information on pap or cervical testing and colposcopy (if you need to have that test).

Please follow up, you need: ____

____

____

Please call us so we can make an appointment. We are also available to discuss this over the telephone. We hope to hear from you soon.

Provider or contact person: ____

Best time to call: ____

☐ **Auburn Public Health Center (206) 296-8400**
20 Auburn Ave., Auburn, WA 98002

☐ **Columbia Public Health Center (206) 296-4650**
4400-37th Ave. So., Seattle, WA 98118

☐ **Downtown Public Health Center (206) 296-4755**
2124-4th Ave., Seattle, WA 98121

☐ **Eastgate Public Health Center (206) 296-4920**
14350 S.E. Eastgate Way, Bellevue, WA 98007

☐ **Federal Way Public Health Center (206) 296-8410**
33431 13th Place So., Federal Way, WA 98003

☐ **Kent Public Health Center (206) 296-4500**
1404 S. Central Ave. Suite #112, Kent, WA 98032

☐ **Kent Teen Clinic (206) 296-7450**
233 2nd Ave. So., Kent, WA 98032

☐ **North Public Health Center (206) 296-4765**
10501 Meridian Ave. North, Seattle, WA 98133

☐ **Northshore Public Health Center (206) 296-9787**
10808 N.E. 145th Street, Bothell, WA 98011

☐ **Renton Public Health Center (206) 296-4700**
3001 N.E. 4th, Renton, WA 98056

☐ **White Center Public Health Ctr (206) 296-4620**
10821-8th Ave. S.W., Seattle, WA 98146

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Fecha: ________________________

Estimada: ________________________

Se hizo: papanicolaou colposcopía en_____________

El resultado de su examen fue:_____________________________________

Estos resultados indican que usted necesita repetir su examen de papanicolaou o una evaluación adicional para un posible tratamiento de su cuello uterino. Un papanicolaou anormal significa un posible riesgo de tener cáncer en el cuello uterino y si no le da seguimiento usted puede correr el riesgo de desarrollar el cáncer cervical. Sin tratamiento el cáncer cervical podría resultar en una histerectomía y/o la muerte.

Adjunto encontrará información acerca del papanicolaou, examen del cuello uterino y colposcopía.

Usted necesita: ____
____
____

Por favor darle seguimiento. Llámenos para que podamos hacerle una cita.
Estamos disponibles si usted desea hacernos una consulta telefónica. Esperamos su llamada a la brevedad posible.

Personal médico o persona para contactar: ___________________________

La mejor hora para llamar: ____

- ❑ **Auburn Public Health Center (206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center (206) 296-4650**
  4400-37th Ave. So., Seattle, WA 98118
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  14350 S.E. Eastgate Way, Bellevue, WA 98007
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  10821-8th Ave. S.W., Seattle, WA 98146

Abnormal Pap Tracking Alert Slip

Last Updated: 8/2/01

(Xerox on pink paper, cut into four slips, put holes on top of each slip)

This client is involved in PAP Follow-Up.

Please check care plan and update current contact information with each visit

This client is involved in PAP Follow-Up.

Please check care plan and update current contact information with each visit

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This client is involved in PAP Follow-Up.

Please check care plan and update current contact information with each visit

This client is involved in PAP Follow-Up.

Please check care plan and update current contact information with each visit

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Date:________________

Dear ______________________________:

Your test which was done on ______________has come back abnormal.

- ❑ You should be treated with antibiotics as soon as possible. Please call the clinic for an appointment immediately. Your partner(s) should also be treated. They may make an appointment to be seen here, or by another provider.
- ❑ You need further testing and evaluation and you may have a condition which needs treatment.

Please call your clinic below for a follow-up appointment.

Sincerely,

____

PHSKC Clinic Staff

- ❑ **Auburn Public Health Center (206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center (206) 296-4650**
  4400-37th Ave. So., Seattle, WA 98118
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  10821-8th Ave. S.W., Seattle, WA 98146

Updated: 9/07

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Fecha:__________

Estimada (o):________________________

Su prueba realizada el día:__________ tiene un resultado anormal.

> Usted deberá empezar un tratamiento con antibióticos lo más pronto posible. Por favor llame inmediatamente a nuestra clínica para hacer una cita. Su(s) pareja(s) también debe(n) ser tratada(o)(s). Puede(n) hacer una cita en nuestra clínica o en cualquier otro centro médico.
>
> Usted necesita pruebas adicionales y una evaluación, pudiera ser que tenga una condición la cual necesite tratamiento.

Por favor llamar a la clínica abajo indicada para hacer una cita.

Sinceramente,

____
PHSKC Personal Médico

- ❑ **Auburn Public Health Center (206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center (206) 296-4650**
  4400-37th Ave. So., Seattle, WA 98118
- ❑ **Downtown Public Health Center (206) 296-4755**
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  10501 Meridian Ave. North, Seattle, WA 98133
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  10808 N.E. 145th Street, Bothell, WA 98011
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  3001 N.E. 4th, Renton, WA 98056
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  10821-8th Ave. S.W., Seattle, WA 98146

Last updated: 6/18/01

Basal Body Temperature Chart

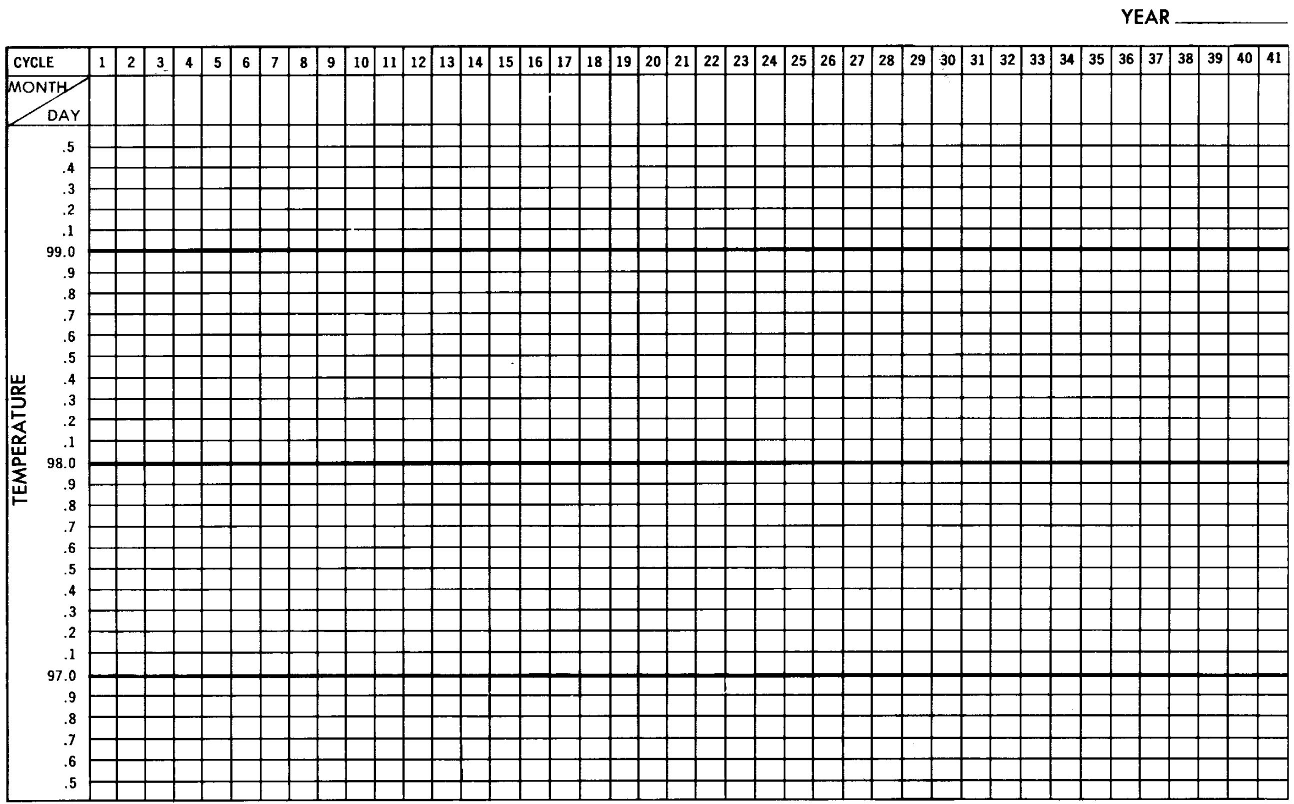
Basal temperature graphs are often helpful in determining if and when ovulation has occurred. In a normal ovulatory cycle, the basal temperature will be 1/2° to 1° higher during the second half of the cycle (post-ovulation) than it will be during the first half of the cycle (pre-ovulation). Ovulation occurs at the time of the shift from the lower temperature levels to the higher temperature levels. This is referred to as a "biphasic graph." If ovulation does not occur, a relatively flat graph is seen, without a definite temperature shift (monophasic graph).

Conception can only occur at or around the time of ovulation. Therefor, intercourse or abstinence should occur at this time, depending on whether pregnancy is desired during this cycle.

DON'T FORGET TO BRING YOUR TEMPERATURE CHART EACH TIME YOU VISIT THE DOCTOR

Directions:

1) A regular fever thermometer or special "metabolic" thermometer may be used.
2) Your temperature should be taken each morning at approximately the same time, immediately on awakening, before eating, talking, smoking, or arising.
3) The thermometer should be placed under your tongue, with the mouth closed, and left in place for five minutes, by the clock or when the electronic alarm sounds.
4) After you have taken your temperature, carefully record it on the graph by means of a dot under the appropriate day. Each daily dot should be joined to the previous day's dot by means of a straight line.
5) Start a new graph with each menstrual cycle. The first day of your menstrual flow is day "1" of the new cycle. Mark an "X" in the space for that day, and for each successive day that the flow continues. Your temperature need not be taken while you are having your menstrual period.
6) After your menstrual cycle has stopped, begin taking your temperature again, as described above.
7) In order to assist your provider in interpreting the graph, it is very important to make the following notations on the chart:
   a) Circle the dot on the days that intercourse occurs and white "a.m." or "p.m." above the circle, as the case may be. Note any pain, vaginal bleeding or spotting, or any unusual vaginal discharge (some women can recognize ovulation by a twinge of lower abdominal pain on either side, by slight vaginal spotting, or a thin vaginal discharge).
   b) Record any recognized causes for temperature changes, such as a cold, other illnesses, indigestion, alcoholic beverages, restless sleep, going to bed late, arising late, etc.
8) It is necessary to record your temperature for at least two or three cycles before the graph is of much value. There will be many variations in individual graphs, which can be best interpreted by your provider.



YEAR ________

TEMPERATURE

CYCLE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41
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YEAR ________

TEMPERATURE

CYCLE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41
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Discharge Routing Sheet

Next Appt Due
❑ 1 year ❑ 6 months ❑ 3 months ❑ 1 month
❑ 2 weeks ❑ 1 week ❑ 3 days ❑ 1-2 days

Type of Appt
❑ annual ❑ initial ❑ pap/pelvic
❑ method check ❑ infection check
❑ pregnancy test ❑ blood draw ❑ BP/OCP
❑ other medical ❑ EGW treatment ❑ IUD
❑ injection ❑ other:

Length of Time Needed for Appt
❑ 10 min ❑ 20 min ❑ 30 min ❑ 40 min

❑ Interpreter: Language:

Provider
❑ any available ❑ specific one:
❑ overbook okay

Eligible for Take Charge ❑ No ❑ Yes
Paperwork for Take Charge submitted ❑

Discharge Teaching Needed
❑ OCP ❑ DMPA ❑ Lunelle ❑ ECP ❑ male condom
❑ Nuvaring ❑ Evra patch
❑ female condom ❑ STD/HIV prevention
❑ BUM for 2 weeks ❑ HCG in 4 weeks
❑ Tobacco Patch/Cessation ❑ ECRR

Contraceptive Prescription Dispensing
❑ OCP brand: ________________ pack # ______
❑ DMPA ❑ Lunelle ❑ other: _________________

STAT Meds or Labs Needed
❑ HCG ❑ Hct/Hgb ❑ UA ❑ other:
❑ injection mg ceftriaxone or:
❑ 1 gram azithro sachet
❑ ECP
❑ **See provider before client leaves**

	Clinic	Phone
❑	**Auburn Public Health Center** 20 Auburn Ave., Auburn, WA 98002	(206) 296-8400
❑	**Columbia Public Health Center** 4400-37th Ave. So., Seattle, WA 98118	(206) 296-4650
❑	**Downtown Public Health Center** 2124-4th Ave., Seattle, WA 98121	(206) 296-4755
❑	**Eastgate Public Health Center** 14350 SE Eastgate Way, Bellevue, WA 98007	(206) 296-4920
❑	**Federal Way Public Health Center** 33431-13th Place S., Federal Way, WA 98003	(206) 296-8410
❑	**Kent Teen Clinic** 613 W. Gowe, Kent, WA 98032	(206) 296-7450
❑	**North Public Health Center** 10501 Meridian Ave N., Seattle, WA 98133	(206) 296-4765
❑	**Northshore Public Health Center** 10808 NE 145th ST., Bothell, WA 98011	
❑	**Renton Public Health Center** 3001 NE 4th, Renton, WA 98056	(206) 296-4700
❑	**White Center Public Health Center** 10821-8th Ave. SW, Seattle, WA 98146	(206) 296-4620

Discharge Routing Sheet

Next Appt Due
❑ 1 year ❑ 6 months ❑ 3 months ❑ 1 month
❑ 2 weeks ❑ 1 week ❑ 3 days ❑ 1-2 days

Type of Appt
❑ annual ❑ initial ❑ pap/pelvic
❑ method check ❑ infection check
❑ pregnancy test ❑ blood draw ❑ BP/OCP
❑ other medical ❑ EGW treatment ❑ IUD
❑ injection ❑ other:

Length of Time Needed for Appt
❑ 10 min ❑ 20 min ❑ 30 min ❑ 40 min

❑ Interpreter: Language:

Provider
❑ any available ❑ specific one:
❑ overbook okay

Eligible for Take Charge ❑ No ❑ Yes
Eligible for Take Charge ❑ No ❑ Yes

Discharge Teaching Needed
❑ OCP ❑ DMPA ❑ Lunelle ❑ ECP ❑ male condom
❑ Nuvaring ❑ Evra patch
❑ female condom ❑ STD/HIV prevention
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Contraceptive Prescription Dispensing
❑ OCP brand: ________________ pack # ______
❑ DMPA ❑ Lunelle ❑ other: _________________

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❑	**White Center Public Health Center** 10821-8th Ave. SW, Seattle, WA 98146	(206) 296-4620

This is a reminder that your 3-month shot of Depo-Provera Contraceptive Injection (medroxyprogesterone acetate injectable suspension) is due on: ____________________________________

You have 7 days after this date to get the shot before you are at risk for pregnancy. If you need to schedule an appointment, need a new birth control method, or have questions, please call us.

- ❑ **Auburn Public Health Center** **(206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
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  10821-8th Ave. S.W., Seattle, WA 98146

DMPA Reminder Card
Xerox to card stock, fold, tape closed, use postcard stamp

Last updated: 1/17/02

This is a reminder that your 3-month shot of Depo-Provera Contraceptive Injection (medroxyprogesterone acetate injectable suspension) is due on:________________________________

You have 7 days after this date to get the shot before you are at risk for pregnancy. If you need to schedule an appointment, need a new birth control method, or have questions, please call us.

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DMPA Reminder Card
Xerox to card stock, fold, tape closed, use postcard stamp

Last updated: 1/17/02

Fold Line

Needs letter postage

TO: ______________________________

____

____

____

Fold Line

Needs letter postage

TO: ______________________________

____

____

____

Alonzo L. Plough, Ph.D., MPH, *Director and Health Officer*

Date:

DSHS
Forms and Publications Warehouse
P.O. Box 45816
Olympia WA 98504-5816
360-753-1528
360-664-0597 (FAX)

To Whom It May Concern:

Please send us the following cards:

We need _____________ ***Domestic Violence Safety Plan Pocket Guide Cards***
(DSHS 22-276 (x) 10/98).

Please send to the address checked below, **Attention: _______________________________**.

- ❑ **Auburn Public Health Center** (206) 296-8400
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  10821-8th Ave. SW, Seattle, WA 98146

FERTILITY AWARENESS

Usual Time of Day _______ a.m.

Month ____________ Year ____________ Cycle Number _____________ Cycle Variation ___________

Basal Body Temperature																																								
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
99.0	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99
	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
98.0	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7
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	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
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97.0	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97
	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9
Cycle Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
Date																																								
Day																																								
Intercourse																																								
Mucus																																								
Cervix																																								
Notes: Mucus Description, Sensation																																								
Disturbances, Schedule Changes, etc.																																								
Method																																								

Mucus Symbols:

*	D	M	(M)	(M̸)
Menses	Dry No Mucus (and dry vaginal sensation)	Non-wet Quality Mucus (and dry vaginal sensation)	Wet Quality Mucus (and wet vaginal sensation)	Last day of Wet Qualiity Mucus (and wet vaginal sensation)

Cervix Symbols: ○ ○ •• ↓ ••

RULES:

- measure temperature after a minimum of 3 hours of sleep
- near ovulation, the cervix is soft and high as estrogen pulls the uterus up and mucus like egg whites = viscous, clear
- eggs live for 12 to 24 hours; and, if a 2nd ovulation happens, it will be within 24 hours of the 1st ovulation
- sperm can live for 5 days
- fertilization is therefore possible 5 days before ovulaiton and 2 days after

Last updated: 8-15-00

HEADACHE DIARY

Date	During Menses?	Time Began (hour AM/PM)	Severity (score)*	Psychic and Physical Factors A	Chemical Exposure B	Describe Location/ Type of Pain	Medication Taken, Dosage	Time Ended (hour AM/PM)	Relief (score)**
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								

Severity Scale *

1	2	3	4	5	6	7	8	9	10
None			Mild			Can't work		Worst, can't do anything	

Relief Scale **

1	2	3	4	5	6	7	8	9	10
Getting worse			Same, unchanged			better			Totally better

A. Psychic and Physical Factors

1 – Emotional upset (family or friends)
2 – Emotional upset (occupational)
3 – Business failure
4 – Business success
5 – Vacation days
6 – Weekend
7 – Strenuous exercise
8 – Strenuous labor
9 – High altitude location (flight)
10 – Anticipation anxiety
11 – Serious crisis
12 – Postcrisis period
13 – New job/position
14 – Moved/housing change
15 – Menstrual days
16 – Physical illness
17 – Oversleeping
18 – Weather
19 – Fasting
20 – Missing a meal
21 – Lack of sleep
22 – Studying
23 – Television/VCR >2 hours
24 – Other:____________________

B. Chemical Exposure

A – Ripened cheeses (or pizza)
B – Herring
C – Chocolate
D – Red vinegar
E – Fermented foods (pickled or marinated, sour cream, yogurt)
F – Freshly baked yeast breads, cakes
G – Nuts, peanut butter
H – Monosodium glutamate (Asian food)
I – Pods or broad beans
J – Onions
K – Canned figs
L – Citrus fruits
M – Bananas
N – Pork
O – Caffeinated beverages (including sodas)
P – Avocado
Q – Smoked or cured sausage, cured cold cuts
R – Chicken livers
S – Wine
T – Alcohol
U – Beer
X – Drugs (specify):____________________

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Date: ________________

To Whom It May Concern:

- ❒ Was seen in our office today.
- ❒ May return to work/school.
- ❒ Recommend a return to work/school on ____________________.

Provider: __________________________________

Public Health - Seattle & King County

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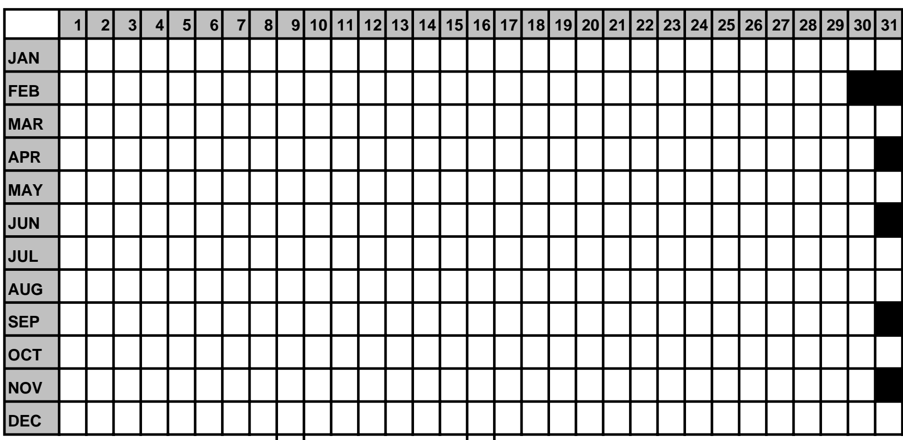
  3001 N.E. 4th, Renton, WA 98056
- ❑ **White Center Public Health Ctr (206) 296-4620**
  10821-8th Ave. S.W., Seattle, WA 98146

Bring this card to your clinic visits

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
JAN																															
FEB																															
MAR																															
APR																															
MAY																															
JUN																															
JUL																															
AUG																															
SEP																															
OCT																															
NOV																															
DEC																															

Type of flow: Blood = X Spotting = S



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	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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JAN																															
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NOV																															
DEC																															

Type of flow: Blood = X Spotting = S

Last updated: 3/20/02

Birth Control Pill Hints

DON'T STOP THE PILL, if you have spotting, bleeding, or no period. **TAKE ONE PILL** at the same time EVERYDAY even during your period.
FIRST TIME ONLY: Start taking the pills on day "1" of your period or the 1st Sunday of your period. Count the first day that you bleed as day "1".
WHEN STARTING THE PILL use a back-up contraception method like condoms for 7 days.
IF YOU FORGET one pill, take it as soon as you remember. Then take the pill for that day at the regular time.
IF YOU FORGET two pills, take two pills for two days and use back-up contraception method like condoms for 7 days.

Call for questions or to make an appointment:

____

Your PAP/Annual is due: _________

Next Shot Due:

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

Public Health Seattle & King County HEALTHY PEOPLE. HEALTHY COMMUNITIES

CS 13.22.92, 450-0496 8/04

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Call for questions or to make an appointment:

Your PAP/Annual is due: _________

Next Shot Due

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

Public Health Seattle & King County HEALTHY PEOPLE. HEALTHY COMMUNITIES

CS 13.22.92, 450-0496 8/04

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IF YOU FORGET two pills, take two pills for two days and use back-up contraception method like condoms for 7 days.

Call for questions or to make an appointment:

____

Your PAP/Annual is due: _________

Next Shot Due:

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

Public Health Seattle & King County HEALTHY PEOPLE. HEALTHY COMMUNITIES

CS 13.22.92, 450-0496 8/04

Birth Control Pill Hints

DON'T STOP THE PILL, if you have spotting, bleeding, or no period. **TAKE ONE PILL** at the same time EVERYDAY even during your period.
FIRST TIME ONLY: Start taking the pills on day "1" of your period or the 1st Sunday of your period. Count the first day that you bleed as day "1".
WHEN STARTING THE PILL use a back-up contraception method like condoms for 7 days.
IF YOU FORGET one pill, take it as soon as you remember. Then take the pill for that day at the regular time.
IF YOU FORGET two pills, take two pills for two days and use aback-up contraception method like condoms for 7 days.

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Next Shot Due:

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

____/____/____ ____/____/____ ____/____/____

CS 13.22.92, 450-0496 8/04

THIS IS YOUR LAST PACK OF BIRTH CONTROL.

Please call NOW to make an appointment for more birth control and you also need:

- ❑ Blood Pressure Checked
- ❑ An Exam

- ❑ Auburn Public Health Center .... (206) 296-8400
- ❑ Columbia Public Health Center .... (206) 296-4650
- ❑ Downtown Public Health Center .... (206) 296-4920
- ❑ Eastgate Public Health Center .... (206) 296-4920
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- ❑ White Center Public Health Center................(206) 296-4620

ESTE ES SU ULTIMO PAQUETE DE MEDICAMENTO.

Por favor <u>llame ahora</u> para hacer una cita para mas medicamento y tambien necesita:

- ❑ Chequear su pression.
- ❑ Un examen anual.

- ❑ Auburn Public Health Center .... (206) 296-8400
- ❑ Columbia Public Health Center .... (206) 296-4650
- ❑ Downtown Public Health Center .... (206) 296-4920
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Pap Reminder Card Example

A Reminder to Call Us

Postage

Name and Address

____
____
____
____

Date Exam Due: ______________________________________
(month/year)

It is time for your yearly women's health exam. Please call us today to make your appointment. We look forward to seeing you again.

Spanish version available as sticker: Ya tiempo para su examen annual de salud femenina. Por favor llamenos el dia de hoy para hacerle una cita. Esperamos poder verla pronto otra vez.

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Return Address Clinic sticker

Date ______________

Dear ______________________________:

Have you forgotten your Pap follow-up? This is extremely important to your health.
In order to have an accurate Pap test, please don't douche, use tampons or have sex for two days before your pelvic exam and Pap test. It is also better for the test if it is done within one or two weeks after your period has ended.

Please follow up, you need: ____

____

____

Please call us so we can make an appointment. We are also available to discuss this over the telephone. We hope to hear from you soon.

Provider or contact person: ____

Best time to call: ____

- ❑ **Auburn Public Health Center (206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center (206) 296-4650**
  4400-37th Ave. So., Seattle, WA 98118
- ❑ **Downtown Public Health Center (206) 296-4755**
  2124-4th Ave., Seattle, WA 98121
- ❑ **Eastgate Public Health Center (206) 296-4920**
  14350 S.E. Eastgate Way, Bellevue, WA 98007
- ❑ **Federal Way Public Health Center (206) 296-8410**
  33431 13th Place So., Federal Way, WA 98003
- ❑ **Kent Public Health Center (206) 296-4500**
  1404 S. Central Ave. Suite #112, Kent, WA 98032
- ❑ **Kent Teen Clinic (206) 296-7450**
  233 2nd Ave. So., Kent, WA 98032
- ❑ **North Public Health Center (206) 296-4765**
  10501 Meridian Ave. North, Seattle, WA 98133
- ❑ **Northshore Public Health Center (206) 296-9787**
  10808 N.E. 145th Street, Bothell, WA 98011
- ❑ **Renton Public Health Center (206) 296-4700**
  3001 N.E. 4th, Renton, WA 98056
- ❑ **White Center Public Health Ctr (206) 296-4620**
  10821-8th Ave. S.W., Seattle, WA 98146

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Fecha ____________________________

Estimada ____________________________

Le recordamos que se ha olvidado hacer una cita para su Papanicolaou: hacerse la prueba es de extrema importancia para su salud.
Para obtener resultados exactos, cuando se haga el Papanicolaou, es recomendable que:

> No utilice duchas vaginales
> No use tampones
> No tenga relaciones sexuales dos días antes del examen pélvico y prueba de Papanicolaou.

También es mejor si la prueba se hace de una a dos semanas después de haber terminado su menstruación.

Por favor llame para poder hacerle una cita. Si Usted desea hacer una consulta, estamos a su disposición telefónicamente. Esperamos su llamada a la brevedad posible.

Proveedor o persona para contactar: ____________________________

La mejor hora para llamar: ____________________________

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Blood Pressure Have your blood pressure checked once a year, more frequently if it is high.		**Total Cholesterol** Have your cholesterol checked every 5 years, more frequently if it is high.		**Weight** Have your weight checked monthly	
Date	Blood Pressure	Date	Total Cholesterol	Date	Weight
Ideal Levels:					
Blood Pressure – Less than 130/85		Cholesterol – Less than 200		Body Mass Index < 26	

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Blood Pressure – Less than 130/85		Cholesterol – Less than 200		Body Mass Index < 26	

Health Tips:

- Do not use tobacco
- Limit alcohol use
- Eat at least 5 fruits or vegetables every day
- Get 8 hours of sleep
- Wear your seatbelt
- Get vigorous exercise at least 3 times a week
- Report abuse or violence
- Use condoms

Clinic Names and Phone Numbers:

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PHSKC Preventative Health Documentation Card

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Last updated: 7/5/01

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PHSKC Preventative Health Documentation Card

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Last updated: 7/5/01

Last Updated:8-15-00

PELVIC SYMPTOM DIARY

Date	During Menses?	Time Began (hour AM/PM)	Severity (score)*	Psychic and Physical Factors A	Chemical Exposure B	Describe Location/ Type of Pain	Medication Taken, Dosage	Time Ended (hour AM/PM)	Relief (score)**
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								
	❑ Yes ❑ No								

Severity Scale *

1	2	3	4	5	6	7	8	9	10
None			Mild			Can't work		Worst, can't do anything	

Relief Scale **

1	2	3	4	5	6	7	8	9	10
Getting worse			Same, unchanged			better			Totally better

A. Psychic and Physical Factors

1 – Emotional upset (family or friends)
2 – Emotional upset (occupational)
3 – Feeling depressed/blue/sad
4 – Business failure
5 – Business success
6 – Vacation or weekend days
7 – Constipation
8 – Strenuous exercise/work
9 – Sexual activity
10 – High altitude location (flight)
11 – Anticipation anxiety
12 – Alcohol or substance use
13 – Accident
14 – New job/position
15 – Moved/housing change
16 – Ovulation time
17 – Painful urination
18 – Oversleeping
19 – Weather
20 – Fasting
21 – Missing a meal
22 – Lack of sleep
23 – Studying
24 – Television/VCR >2 hours
25 – Other:___________________

B. Chemical Exposure

A – Ripened cheeses (or pizza)
B – Chocolate
C – Fermented foods (pickled or marinated, sour cream, yogurt)
D – Freshly baked yeast breads, cakes
E – Nuts, peanut butter
F – Monosodium glutamate (Asian food)
G – Pods or broad beans
H – Onions
I – Citrus fruits
J – Coffee
K – Caffeinated soda
L – Tea
M – Wine
N – Distilled alcohol (spirits)
O – Beer
P – Cocaine
Q - Amphetamine
R – Marijuana
S – Other drugs:__________________

Date:________________

Dear _____________________________:

Your test which was done on ______________has come back and the results are enclosed.

If you have questions about your results please call your clinic below for a follow-up appointment.

Sincerely,

____

PHSKC Clinic Staff

- ❑ **Auburn Public Health Center** **(206) 296-8400**
  20 Auburn Ave., Auburn, WA 98002
- ❑ **Columbia Public Health Center** **(206) 296-4650**
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Place Patient Sticker Here

Updated 6.16.04

Updated: 7.7.05

Voiding Diary

Date:______________

Time	In	Out	Leak

Instructions:

Measure the volume of water you drink and the volume you urinate. Record these times. Document your incontinence or urine leakage.

ABILITY OF MINORS TO CONSENT TO HEALTH CARE
SUMMARY OF LEGAL REQUIREMENTS

Minors are persons less than 18 years of age. The ability of a minor to consent to care may depend upon the type of treatment being sought. For some types of treatment, the statutory law specifically authorizes that minors may provide their own consent. These areas are:

- **Alcohol/Drug Abuse Treatment:** Minors 13 years of age or older can consent to outpatient "counseling, care treatment or rehabilitation" for alcohol/drug abuse from chemical dependency programs certified by DSHS. (RCW 70.96A.095 originally required age of 14 or older; Becca Bill decreased age requirement to 13 years.) Inpatient treatment requires the consent of the parent or legal guardian for all minors unless the child meets the definition of child in need of services in RCW13.32A.030(4)(c).

- **Mental Health Treatment:** Minors 13 years of age or older can consent to outpatient mental health treatment without parental consent [RCW 71.34.030(1)]. To receive inpatient treatment minor 13 or older can voluntarily commit self without parental consent when proper notice is provided to the parents by the facility [RCW 71.34.030(2)].

Statutory law as well as case law expands the ability of minors to provide consent for abortion, birth control and reproductive functions:

- **Abortion, birth control, pregnancy care:** No age requirement for consent to medical care if minor female is capable of giving informed consent. [Reproductive Privacy Act, RCW 9.02 and State v. Koome, 84 Wn.2d901 (1975): right to privacy in matters involving termination of pregnancy and control of one's reproductive functions]

- **Sexually Transmitted Disease/HIV testing:** SKCDPH policy is to provide STD/HIV diagnosis and treatment **regardless of age** due to the Health Department's legally mandated responsibility to prevent the spread of communicable diseases (RCW 70.05.070), the Reproductive Privacy Act (RCW 9.02), and WAC 388-86 on Medical/Care-Emergency Services. Although one state law (RCW 70.24.110) indicates that minors 14 years of age and older can consent to diagnosis or treatment of a sexually transmitted disease, other laws and the Health Department's legal mandate take precedence in this matter.

Treatment without parental consent regardless of age may also be given in the following situations:

- **Minor is married to a person 18 years or older** (RCW26.28.020)

- **Emancipation by court order**

- **Emergency services** (when impractical to get parental consent first)

- **Parent (minor) may consent for treatment of his/her own child**

Mature Minor Rule: In addition to the above referenced statutes and case law which govern a minor's ability to consent based upon the type of care sought, there is a broader legal concept, the Mature Minor Rule, which gives health care providers the ability to make judgments to treat certain youth as adults based upon an assessment and documentation of the young person's situation. The health care provider may consider the minor's age, maturity, intelligence, training, experience, economic independence, and freedom from parental control in determining mature minor status. Generally, age of 15 or older has been considered one of the elements, but this is not as tight a guideline as it used to be. [Smith v. Seibly, 72 Wn.2d 16, (1967)]

Public Health Seattle & King County
Family Planning Program

Client Consent for Emergency Contraception Pills (ECP) by Standing Order

By my signature below, I am indicating that I understand the following information about emergency hormonal contraception:

- My chances of pregnancy following unprotected intercourse are about 1 in 12. Emergency Contraception Pills (ECP) can reduce this risk down to about 1 in 50. I realize that I am not guaranteed that I will not get pregnant and I will hold PHSKC harmless if that occurs.
- ECPs work better the sooner they are taken after unprotected intercourse. The earlier I take the pills, the more effective they will be. If I decide to try ECPs beyond 5 days, I understand the chance of working is a lot less.
- ECPs work like birth control pills, except they are a stronger dose. ECPs prevent pregnancy by blocking ovulation (an egg). ECPs are not an abortion pill and if you are already pregnant they will not work.
- I may have some nausea or even vomiting with this medication.
- Other possible side effects of ECPs include: bleeding, abdominal pain, breast tenderness, headache, dizziness and fatigue.
- I will probably have my next menstrual period within one week before or after the expected time for my period. If I do not have bleeding by 3 weeks from taking the ECP I know I could be pregnant and I will need to return for a pregnancy test.
- If the ECP does not work I know I could be pregnant and very rarely this can be an ectopic or tubal pregnancy and this could be life threatening.
- ECPs do not prevent pregnancy from unprotected sex occurring after the ECP. I should use another form of birth control after using ECP.
- ECPs do not protect me against sexually transmitted diseases (STDs), including HIV.
- ECPs are not known to cause damage to the fetus if used accidentally during early pregnancy.
- I should seek follow-up care if I need ongoing birth control or family planning care, have a delay in my next period of more than one week, suspect that I may be pregnant, or have other reasons for concern.

I have had an opportunity to ask questions and have them answered to my satisfaction. I hereby consent to receiving emergency hormonal contraception (ECP) pills administered by PHSKC.

______________________	______________________
Date	Signature of Patient
______________________	______________________
Witness	Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Salud Pública, Condados de Seattle y King
Programa de Planificación Familiar

Consentimiento de la cliente para Obtener Píldoras Anti-conceptivas de Emergencia (ECP) por Pedido Permanente

Al firmar debajo, indico que entiendo la siguiente información acerca de la anticoncepción hormonal de emergencia:

- Mis probabilidades de embarazo después de haber tenido relaciones sexuales sin protección son alrededor de 1 en 12. Las Píldoras anticonceptivas de Emergencia (ECP) pueden reducir este riesgo hasta alrededor de 1 en 50. Entiendo que no se me garantiza que no quedaré embarazada y mantendré a PHSKC indemne si eso sucediera.
- Las ECPs funcionan mejor mientras más pronto se tomen después de una relación sexual sin protección. Mientras más pronto tome las píldoras, más eficaces serán. Si decido tratar de tomar las ECPs después de 5 días, entiendo que la probabilidad de que funcionen será mucho menor.
- Las ECPs funcionan como píldoras de control de la natalidad, excepto que son una dosis más fuerte. Las ECPs previenen el embarazo bloqueando la ovulación (un óvulo). Las ECP no son píldoras abortivas y si usted ya está embarazada estas no funcionarán.
- Yo podría sentir algo de nauseas o incluso vómitos con este medicamento.
- Otros efectos colaterales posibles de las ECP incluyen: sangrado, dolor abdominal, sensibilidad en los senos, dolor de cabeza, mareo y fatiga.
- Probablemente tenga mi próximo periodo menstrual dentro de una semana antes o después del momento esperado de mi periodo. Si no tengo sangrado hasta 3 semanas después de haber tomado las ECP, entiendo que podría estar embarazada y tendré que volver para un examen de embarazo.
- Si las ECP no funcionan, sé que podría estar embarazada y que muy rara vez podría tratarse de un embarazo ectópico o en las trompas de Falopio y que esto puede ser crítico.
- Las ECP no previenen el embarazo a consecuencia de relaciones sexuales sin protección que ocurrieron después de haber tomado las ECP. Debo utilizar otra forma de control de la natalidad después de utilizar las ECP.
- Las ECP no me protegen contra las enfermedades transmitidas sexualmente, incluyendo el VIH.
- Las ECP no son causa conocida de daño al feto si se utilizan accidentalmente durante el comienzo del embarazo.
- Debo buscar atención complementaria si necesito control de la natalidad en forma continua o atención de planificación familiar, si tengo un retraso en mi próximo período de más de una semana, sospecho que podría estar embarazada, o si tengo otros motivos de preocupación.

He tenido la oportunidad de hacer preguntas y las han respondido a mi satisfacción. Por el presente, consiento en recibir las píldoras de anticoncepción hormonal de emergencia (ACP) administradas por PHSKC.

____________________ Fecha	____________________ Firma de la paciente
____________________ Testigo	____________________ Intérprete

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health Seattle & King County
Family Planning Program

Client Consent for Emergency Contraception Pills (ECP) by Standing Order

By my signature below, I am indicating that I understand the following information about emergency hormonal contraception:

- My chances of pregnancy following unprotected intercourse are about 1 in 12. Emergency Contraception Pills (ECP) can reduce this risk down to about 1 in 50. I realize that I am not guaranteed that I will not get pregnant and I will hold PHSKC harmless if that occurs.
- ECPs work better the sooner they are taken after unprotected intercourse. The earlier I take the pills, the more effective they will be. If I decide to try ECPs beyond 5 days, I understand the chance of working is a lot less.
- ECPs work like birth control pills, except they are a stronger dose. ECPs prevent pregnancy by blocking ovulation (an egg). ECPs are not an abortion pill and if you are already pregnant they will not work.
- I may have some nausea or even vomiting with this medication.
- Other possible side effects of ECPs include: bleeding, abdominal pain, breast tenderness, headache, dizziness and fatigue.
- I will probably have my next menstrual period within one week before or after the expected time for my period. If I do not have bleeding by 3 weeks from taking the ECP I know I could be pregnant and I will need to return for a pregnancy test.
- If the ECP does not work I know I could be pregnant and very rarely this can be an ectopic or tubal pregnancy and this could be life threatening.
- ECPs do not prevent pregnancy from unprotected sex occurring after the ECP. I should use another form of birth control after using ECP.
- ECPs do not protect me against sexually transmitted diseases (STDs), including HIV.
- ECPs are not known to cause damage to the fetus if used accidentally during early pregnancy.
- I should seek follow-up care if I need ongoing birth control or family planning care, have a delay in my next period of more than one week, suspect that I may be pregnant, or have other reasons for concern.

I have had an opportunity to ask questions and have them answered to my satisfaction. I hereby consent to receiving emergency hormonal contraception (ECP) pills administered by PHSKC.

______________________________	______________________________
Date	Signature of Patient
______________________________	______________________________
Witness	Interpreter

Place Patient Information Sticker Here
OR Name & DOB

Public Health – Seattle & King County
INFORMED CONSENT FOR CERVICAL CRYOTHERAPY

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment;
2. Anticipated results of the proposed treatment;
3. Alternative forms of treatment, including non-treatment; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment.

❑ **Cervical Cryotherapy Procedure**
I understand that I have precancerous cells on the surface of my cervix. These can be treated in the office with cryotherapy. Cryotherapy is a procedure in which a slender instrument is placed into a woman's vagina and held against her cervix. The end of the instrument is then chilled to freezing temperatures to destroy those abnormal cells. The freezing continues for about three minutes, then here is about a two minute interruption and the treatment is continued for another three minutes. During the freezing, I may experience some uterine cramping. These cramps will lessen when the treatment is over. The discomfort may be treated with any medication I usually take for menstrual cramps.

❑ **Possible Complications**
Rarely are there complications from cryotherapy. These include infection, bleeding, miscarriage (if I am pregnant), and possible scarring of my cervix in the future. If I experience any abnormal bleeding, abdominal pain, fevers and chills in the coming weeks, I will return for evaluation or go to an emergency room. After I go home I understand that I will have a watery vaginal discharge or 3-4 weeks. This is the time when my cervix is healing. It is vital that I do not put anything into my vagina during the healing time. This means I should not have sexual intercourse or use tampons for the next month.

❑ **Follow Up**
In order to make certain that my problem has been successfully treated and does not come back, I will need to return to have pap cervical cytology tests every six months for the next two years. About 15% of women cannot be treated by cryotherapy alone and will need another form of treatment like excision (cutting) to prevent invasive cancer of the cervix and this might have to be done by a hospital

❑ I understand the above risks and request cryotherapy of my cervix by PHSKC.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

____________________ ______________________________________
Date Signature of Patient / Other Legally Responsible Person if Applicable

____________________________ ______________________________
Witness Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Public Health – Seattle & King County
INFORMED CONSENT FOR COLPOSCOPY BIOPSY

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment;
2. Anticipated results of the proposed treatment;
3. Alternative forms of treatment, including non-treatment; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment.

❑ **Colposcopy and Biopsy Procedure**
I understand that this procedure will involve looking with a microscope at my cervix for abnormal precancerous (dysplastic) cells using dilute acetic acid (vinegar) if abnormal cells are seen then a small sampling of tissue (biopsy) will be taken from my cervix with an instrument called a forcep. A chemical called silver nitrate would then be used to make any bleeding stop. There may be some cramping and discomfort during the procedure. A numbing medicine may also be used like lidocaine or benzocaine on my cervix before the biopsy. Rarely, an endocervical curettage (ECC) would be performed and this involves a spoon like instrument placed into the opening of the cervix to scrape cells from inside where we cannot see them. Many times a biopsy many not be needed if there is no evidence of precancer seen by colposcopy.

❑ **Alternatives to the Procedure (if any) have been discussed with me.**

❑ **Benefits of the Procedure:**
- ❑ Help to make a diagnosis of my abnormal pap test
- ❑ May detect cancer of the cervix or pre-cancerous changes
- ❑ Help to plan treatment, if needed

❑ **Risks of the Procedure:**
- ❑ Cramping pain during procedure and 2-3 days after procedure
- ❑ Bleeding, (may occur for several days after procedure)
- ❑ Infection in the cervix or tissue around cervix
- ❑ Allergic reaction to medications ❑ I am not allergic to lidocaine ❑ I am not allergic to benzocaine
- ❑ Can faint from procedure
- ❑ Disruption of unknown pregnancy
- ❑ Missed abnormal tissue (10% risk) & need for further evaluation & possible surgical procedure
- ❑ If no biopsy is done it is important to get another pap in 6-12 months because sometimes abnormal cells can be missed or are too small to see.

❑ **Importance of the follow-up visit to discuss results and possible treatment if needed has been told to me and if I had a biopsy I will make a follow-up visit in 2 weeks to get the results.**

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

____________________ Date

____________________ Signature of Patient / Other Legally Responsible Person if Applicable

____________________ Witness

____________________ Interpreter

Place Patient Information Sticker Here
OR Name & DOB

Public Health – Seattle & King County

Contraceptive Iplant Consent for Insertion or Reoval Form

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment is to place an implant system for contraception;
2. Anticipated results of the proposed treatment is to have an implant system;
3. Alternative forms of treatment, including non-instrumented methods like pills, patches, barrier methods or shots;
4. Possible risks, complications, and anticipated benefits involved in the proposed treatment which are discussed below.

❑ **Iplant Insertion**

I understand that this procedure will insert a plastic device with progestin into the skin of my upper arm for birth control. I understand that a needle will be used to put in numbing medicine into my skin and then a sharp instrument will be inserted to place the implant under my skin. The skin will then be closed with a type of tape.

❑ **Reo val Procedure**

I understand that it could take up to 15 minutes to remove the implant system using instruments to pull out the implant and to remove scar tissue around the implant. If it can not be removed, I understand that I will need to be referred for an ultrasound or MRI to find the implant.

❑ **Possible Risks and ip ortant information about the insertion procedure for the Iplanon? System**

- ❑ No birth control method is 100% effective. 1 out of 500 women can get pregnant using an implant system.
- ❑ Irregular bleeding is very common with implant use. Some women may not have bleeding with implant use.
- ❑ Some women can get headaches, mood changes, or hair loss with implant use.
- ❑ Bruising or swelling of the skin from the procedure is common and can last for 1 to 2 weeks.
- ❑ Sometimes the procedure can cause a permanent scar or change in color of the skin above the implant.
- ❑ Rarely (2 in 100), a mild infection in the skin can happen. It is important to come to the clinic if you have a fever or a lot of pain. Very rarely the implant system can come out of the skin if the infection is bad.
- ❑ Very rarely an injury can happen to your arm nerves, blood vessels, or muscles from the procedure.
- ❑ Allergic reaction to medication for the procedure. I am not allergic to: ❑ betadine ❑ lidocaine ❑ tape.
- ❑ I do not think I am pregnant today: ❑ Agree ❑ Unsure
- ❑ The implant system will not protect you from pregnancy until it has been in place for 7 days, unless it is placed within 5 days after the start of your period.
- ❑ If you are worried the implant has failed and that you may be pregnant, it is important that you are seen in the clinic as soon as possible.

❑ **Possible Risks and ip ortant information about the Reo val procedure for the Iplanon? System**

- ❑ Rarely a mild infection in the skin can happen. It is important to come to the clinic if you have a fever, redness of the skin, pus near the insertion site or a lot of pain.
- ❑ When you have the implant system removed you can get pregnant immediately.

❑ I have read the manufacturer's brochure and I have chosen to have the 3 year Implanon rod placed.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All of my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

____________ ____

Date Signature of Patient/Other Legally Responsible Person if Applicable

____________________________ ____________________________________

Witness Interpreter

Consent: Contraceptive Implant

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health & Seattle & King County
999 Third Ave, Suite 900
Seattle, WA 98104
Phone: 206-296-4600

Client Name: ____________________________

HR #: ________________________________

D. O. B. : ________________

Public Health – Seattle & King County

INFORMED CONSENT FOR ENDOMETRIAL BIOPSY

I hereby authorize the medical staff of Public Health – Seattle & King County to provide the treatment listed below. I have been advised of the:

1. Nature and character of the proposed treatment;
2. Anticipated results of the proposed treatment;
3. Alternative forms of treatment, including non-treatment; and
4. Recognized possible risks, complications, and anticipated benefits involved in the proposed treatment.

❑ **Endometrial Biopsy Procedure**
I understand that this procedure will take a small sampling of tissue from the lining of the uterus and have been told the purpose of the procedure. I understand that a thin plastic catheter will be inserted into the uterus and a sample of tissue from the uterine lining will be obtained under suction. There may be some cramping and discomfort during the procedure. Occasionally the cervix may need to be dilated to pass the catheter into the uterus which may cause cramping. A numbing medicine may be used like lidocaine or benzocaine on the cervix.

❑ **Alternatives to the Procedure (if any) have been discussed with me.**

❑ **Importance of follow-up to discuss results, treatment, possible referral & repeat biopsy if needed.**

❑ **Benefits of the Procedure:**
- ❑ Help to make a diagnosis of my condition
- ❑ May detect cancer of the uterus or pre-cancerous changes
- ❑ Help to plan future therapy

❑ **Risks of the Procedure:**
- ❑ Cramping pain during procedure and 1-2 days after procedure
- ❑ Bleeding, (may occur for several days after procedure)
- ❑ Infection in the uterus or tissue around uterus
- ❑ Perforation (hole in uterine wall) of uterus (very rare with plastic sampler device)
- ❑ Allergic reaction to medications ρ betadine ρ lidocaine ρ benzocaine
- ❑ Can faint from procedure
- ❑ Disruption of unknown pregnancy
- ❑ Missed abnormal tissue (2-6% risk) & need for further evaluation & possible surgical procedure
- ❑ Rare unusual reaction following any surgical procedure

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment with the following signature:

____________________ ______________________________________
Date Signature of Patient / Other Legally Responsible Person if Applicable

__________________________ ______________________________
Witness Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

Salud Pública de Seattle y el Condado de King
Programa de Planificación Familiar

Consentimiento Informado Para Atención De Planificación Familiar

Nombre (en letra de molde por favor) _ ____

Me explicaron varios métodos de control de la natalidad. Estos podrían haber incluido la abstinencia, planificación familiar natural, condones masculinos y femeninos, diafragmas, implantes, inyecciones, DIU (dispositivos intrauterinos), esterilización, y la píldora, parches o anillos para el control de la natalidad. Estoy consciente del uso, la efectividad y los efectos colaterales y complicaciones conocidos de cada uno de los métodos que se debatieron conmigo. Entiendo la información que se me ha proporcionado acerca de cada método y he tenido la oportunidad de hacer preguntas. Asimismo, entiendo que ningún tipo de control de la natalidad es 100% seguro para evitar el embarazo.

He proporcionado a la Clínica de Planificación Familiar un historial médico correcto acerca de mi salud o la de mi familia. Entiendo que se me ofrecerá un examen médico antes de darme un método para el control de la natalidad. Este examen podría incluir: un examen testicular, examen pélvico, examen mamario, examen de Papanicolau, análisis de sangre, análisis de orina, análisis de enfermedades transmitidas sexualmente, chequeo de presión sanguínea, estatura, peso, una prueba de embarazo y otras pruebas que el proveedor de planificación familiar podría decidir que son necesarias, sobre la base de mi género e historial médico.

Entiendo que, luego del examen, se me proporcionará un método para el control de la natalidad basado en mis requerimientos y las conclusiones médicas del examen. Entiendo que debería informar a esta clínica sobre cualquier problema de salud que pueda estar relacionado con mi método de control de la natalidad. Se me ha informado que debo llamar al 911 o buscar atención urgente en un establecimiento local, en caso de surgir problemas graves cuando esta clínica no esté abierta.

He leído este formulario y entiendo la información contenida en el mismo.

______________________	____
Fecha	Firma del paciente / otra persona legalmente responsable según corresponda
______________________	____
Testigo	Intérprete

Informed Consent: Family Planning Care

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
401 5th Ave. Suite #1000
Seattle, WA 98104
Phone: 206-263-8354
Fax: 206-205-6236

Client Name: ______________________________

HR #: ______________________________

D.O.B. : ____________________

Consentimiento informado para un método
Anticonceptivo Hormonal

Efectividad

Estoy consciente de que las hormonas anticonceptivas no son 100% efectivas, y que son más efectivas cuando se toman correctamente. Se me ha informado que debo usar un método de respaldo, tales como condones o debo abstenerme de tener relaciones sexuales, durante los primeros 7 días desde su inicio.

Beneficios

Se me ha informado que las hormonas anticonceptivas pueden tener algunos de los siguientes beneficios:

- disminución de los calambres y sangrado menstruales
- mejora del acné
- menor riesgo de algunos tipos de quistes en los ovarios
- protección contra el cáncer de ovarios y endometrial

Efectos Colaterales

Se me ha informado que en algunas ocasiones las hormonas para el control de la natalidad pueden ocasionar uno o más de los siguientes problemas en las mujeres, los que normalmente mejorarán con el tiempo:

- nausea si se usan estrógenos
- manchas o sangrado entre los períodos
- cambios de humor o en el libido
- cambios o sensibilidad en los senos
- dolores de cabeza
- En raras ocasiones puede haber pérdida de cabello
- En raras ocasiones puede ocurrir el oscurecimiento de la piel de la cara, cuando se usan estrógenos

Riesgos

La hormona que se usa como anticonceptivo, llamada estrógeno, puede estar asociada con coágulos de sangre en las piernas o los pulmones, accidentes cerebrovasculares, ataques cardiacos, presión sanguínea alta, enfermedad de la vesícula biliar y alteraciones del hígado. Estos problemas raramente resultan ser fatales. Estos riesgos pueden aumentar si una mujer tiene 35 años de edad o más, fuma, tiene niveles altos de colesterol o un historial médico familiar de coágulos sanguíneos o enfermedades cardiacas. Se desconoce, pero es posible que el uso del parche pueda incrementar el riesgo de coágulos sanguíneos. Se me ha informado que, para disminuir las posibilidades de problemas graves, es mi respon-sabilidad acudir a la sala de emergencias de un hospital si empiezo a tener cualesquiera de los siguientes síntomas:

- dolores abdominales severos
- dolores severos en el pecho o falta de aire
- dolores severos de cabeza
- problemas oculares, tales como visión borrosa o pérdida de la visita
- dolores severos y/o hinchazón en las piernas

Se me ha informado que, si uso la inyección de medroxiprogesterona ("Depo") mis ovarios no producirán mucho estrógeno, y que esto puede conducir a la pérdida de densidad ósea, lo cual puede incrementar el riesgo de fracturas de los huesos más adelante en la vida, especialmente si la uso por más de 2 años.

Alternativas

Se me ha ofrecido información sobre todos los métodos de contracepción y se me ha informado que las hormonas anticonceptivas no protegen contra las enfermedades transmitidas sexualmente y que solamente el uso apropiado de condones puede reducir el riesgo de infección.

Preguntas

He tenido la oportunidad de hacer preguntas. Puedo solicitar una copia de este formulario. Entiendo que se me darán las instrucciones para el uso adecuado de cada método específico de control de la natalidad que yo elija, junto con las instruccion es de empleo de la empresa. Elijo de manera voluntaria recibir anticonceptivos hormonales y lo indico así al firmar más abajo.

______________________ ______________________________________

Fecha — Firma del paciente / otra persona legalmente responsable, según corresponda

______________________ ______________________________________

Testigo — Intérprete

Informed Consent: Family Planning Care

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Public Health – Seattle & King County
401 5th Ave. Suite # 1000
Seattle, WA 98104
Phone: 206-263-8354
Fax: 206-205-6236

Client Name: ______________________

HR #: ______________________

D.O.B. : ______________________

Public Health – Seattle & King County
Family Planning Program

Informed Consent for Family Planning Care

Name (Please Print) ____

Several birth control methods have been explained to me. These may include abstinence, natural family planning, male and female condoms, diaphragm, implants, injections, IUD, sterilization, and birth control pill, patch, or ring. I am aware of the use, effectiveness, and known side effects and complications of each method discussed with me. I understand the information I have been given about each method and have had a chance to ask questions. I also understand that no type of birth control is 100% certain to prevent pregnancy.

I have given the Family Planning Clinic a correct medical history about my health or my family's health. I understand that I will be offered a physical exam before a birth control method is given to me. This exam may include: testicular exam, pelvic exam, breast exam, pap test, blood test, urine test, sexually transmitted disease tests, blood pressure check, height, weight, a test for pregnancy, and other tests the Family Planning provider may decide are needed based on my gender and medical history.

I understand that after the exam I will be given a birth control method based on my needs and the medical findings of the exam. I understand that I should report to this clinic any health problems which may be related to my birth control method. I have been told to call 911 or seek urgent care at a local facility if severe problems occur when this clinic is not open.

I have read this form and understand the information in it.

______________________ Date

______________________ Signature of Patient / Other Legally Responsible Person if Applicable

______________________ Witness

______________________ Interpreter

Public Health – Seattle & King County
401 5th Ave. Suite # 1000
Seattle, WA 98104
Phone: 206-263-8354
Fax: 206-205-6236

Client Name: ______________________

HR #: ______________________

D.O.B.: ______________________

Public Health Seattle & King County
Family Planning Program

INFORMED CONSENT FOR FAMILY PLANNING CARE

Name (Please Print) ____

Several birth control methods have been explained to me. These may include abstinence, natural family planning, male and female condoms, diaphragm, implants, injections, IUD, sterilization, and birth control pill, patch, or ring. I am aware of the use, effectiveness, and known side effects and complications of each method discussed with me. I understand the information I have been given about each method and have had a chance to ask questions. I also understand that no type of birth control is 100% certain to prevent pregnancy.

I have given the Family Planning Clinic a correct medical history about my health or my family's health. I understand that I will be offered a physical exam before a birth control method is given to me. This exam may include: testicular exam, pelvic exam, breast exam, pap test, blood test, urine test, sexually transmitted disease tests, blood pressure check, height, weight, a test for pregnancy, and other tests the Family Planning provider may decide are needed based on my gender and medical history.

I understand that after the exam I will be given a birth control method based on my needs and the medical findings of the exam. I understand that I should report to this clinic any health problems which may be related to my birth control method. I have been told to call 911 or seek urgent care at a local facility if severe problems occur when this clinic is not open.

I have read this form and understand the information in it.

____________________ ____
Date | Signature of Patient / Other Legally Responsible Person if Applicable

____________________ ____
Witness | Interpreter

Public Health
Seattle & King County
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Place Patient Information Sticker Here
OR Name & DOB

Family Planning Consent Form, 450-0320
CS 13.22.13, Page 1
Last updated 06/09/05

Informed Consent for
A HORMONAL CONTRACEPTIVE Method

EFFECTIVENESS
I am aware that the birth control hormones are not 100% effective, and they are most effective if taken correctly. During the first 7 days of starting, I have been advised that I must use a back-up method, such as condoms or no sex.

BENEFITS
I have been told that the birth control hormones may have some of the following benefits:
-decreased menstrual cramps and bleeding
-improvement in acne
-less risk of certain types of ovarian cysts
-protection against ovarian and endometrial cancer

SIDE EFFECTS
I have been told that the birth control hormones may sometimes give some women one or more of the following problems which usually get better with time:
-nausea if estrogen used
-spotting or bleeding between periods
-mood or changes in sex drive
-breast changes or tenderness
-headaches
-Rarely there can be hair loss
-Rarely if estrogen used there can be darkening of the skin of the face

RISK
The birth control hormone estrogen may be associated with blood clots of the legs or lungs, strokes, heart attacks, high blood pressure, gallbladder disease, and liver changes. These problems may rarely result in death. These risks may be increased if a woman is age 35 or older, is a smoker, has high cholesterol, or has a family history of blood clots or heart disease. It is unknown but possible that using the patch can increase this risk of blood clots. I have been told that in order to lessen the chances of serious problems, it is my responsibility to go to a hospital emergency room if I start to have any of the following symptoms:
-severe abdominal “belly” pain
-severe chest pain or shortness of breath
-severe headaches
-eye problems such as blurred vision, or loss of vision
-severe leg pain and/or swelling
If I use the medroxprogesterone shot (“Depo”) I have been told my ovaries will not make much estrogen and this can lead to loss of bone density which can increase my risk of bone fracture later in life especially if I use it for more than 2 years

ALTERNATIVES
I have been offered information on all methods of contraception, and I have been told that birth control hormones do not protect against sexually transmitted diseases and only proper condom use can reduce the risk of infection.

QUESTIONS
I have had the opportunity to ask questions. I may request a copy of this form. I understand I will be given the instructions for the proper use of each specific birth control method I choose along with the package insert from the company. I am voluntarily choosing to receive hormonal contraceptives and indicate this by my signature below.

____
Date Signature of Patient / Other Legally Responsible Person if Applicable

_________________________________ _________________________________
Witness Interpreter

Place Patient Information Sticker Here
OR Name & DOB

Consent Form: Birth Control Method

Patient consent statement:

I ____, am requesting the method of contraception checked below, at my own choice. I have been given an opportunity to ask questions about all forms of birth control, including all prescription, non-prescription, and natural methods. All of my questions have been answered to my satisfaction and I understand all of the answers.

I have also received and understand the verbal and written information on the benefits, risks, side effects, warning signs, alternatives, instructions and decision to discontinue use if I choose.

__________ (Initials) I have received printed information specific to my chosen contraceptive method.

__________ (Initials) I consent to taking the following prescribed birth control method:

	*Date Given	Clients Initials	Provider Initials
Birth control pills, – combined estrogen and progesterone	____________	____________	____________
Birth control pills, – progesterone only pill	____________	____________	____________
Condoms – Female	____________	____________	____________
Condoms – Male	____________	____________	____________
Diaphragm	____________	____________	____________
Emergency Contraceptive Pill (Plan B)	____________	____________	____________
Progesterone only injection, (Depo Provera)	____________	____________	____________
Patch (Ortho Evra)	____________	____________	____________
Vaginal Ring (Nuva Ring)	____________	____________	____________
Other (Specify)	____________	____________	____________

____ ______________________________
Patient's Signature Date

____ ______________________________
Provider Signature Date

*Initial and date for every method change.

Informed Consent: Birth Control Method Specific

Public Health
Seattle & King County

Family Planning
Public Health – Seattle & King County
401 Fifth Avenue, Suite 1300
Seattle, WA 98104
Phone: 206-296-4600
Fax: 206-296-0166

Form #: PH-0143 (12/07)

Client Name: ______________________________

HR #: ______________________________

D.O.B.: ____________________

1202M

Inventory #: 450-0556

Distribution: **White – Health Records**

CONSENT FORM
FORMULARIO DE CONSENTIMIENTO

I have read the patient information booklet and have had my questions about MIRENA® answered. I choose to have MIRENA® inserted by
He leído el folleto de información para pacientes y he recibido respuesta a todas mis preguntas acerca del dispositivo MIRENA®. *He decidido que el dispositivo* MIRENA® *sea colocado por*

____
Health care Provider's Name
Nombre del médico

______________________________ ____________
Patient's Signature — Date/*Fecha*
Firma de la paciente

The patient has signed this consent form in my presence after I counseled her and answered her questions.
La paciente ha firmado este formulario de consentimiento en mi presencia después de haberla asesorado y respondido a sus preguntas.

______________________________ ____________
Health care Provider's Signature — Date/*Fecha*
Firma del médico

The system is scheduled for removal on ______________
El dispositivo debe ser retirado por el médico el Date/*Fecha*

Manufactured for:
Fabricado para:

BERLEX®

Berlex Laboratories, Montville, NJ 07045
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Manufactured in Finland

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Fabricado en Finlandia

Patient Consent

I have read this brochure in its entirety and discussed its contents with my clinician. My clinician has answered all my questions and has advised me of the risks and benefits associated with the use of ParaGard® T 380A, with other forms of contraception, and with no contraception at all.

I have considered all these factors and voluntarily choose to have ParaGard® T 380A inserted by

______________________________ on date ______________
Clinician

Patient Signature ______________________________

The patient has signed this brochure in my presence after I counseled her and answered all her questions.

______________________________ ______________
Clinician — Date

This ParaGard® T 380A is scheduled for removal on ______________

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ECR #1360
1016800

Form Approved: OMB No. 0937-0166
Expiration date: 11/30/2009

CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from ______________________ (*doctor or clinic*). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal Funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a ______________________. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: ____________ (*Month Day Year*)

I, ______________________, hereby consent of my own free will to be sterilized by ______________________ (*doctor*) by a method called ______________________. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

______________________ *Date:* ____________
Signature *Month Day Year*

You are requested to supply the following information, but it is not required: *(Ethnicity and Race Designation) (please check)*

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in ______________________ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

______________________ ____________
Interpreter's Signature *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before ______________________ (*name of individual*) signed the consent form, I explained to him/her the nature of sterilization operation ______________________, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

______________________ ____________
Signature of person obtaining consent *Date*

____
Facility

____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon ______________________ (*name of individual*) on ____________ (*date of sterilization*). I explained to him/her the nature of the sterilization operation ______________________ (*specify type of operation*), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(**Instructions for use of alternative final paragraphs**: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: ____________
- ☐ Emergency abdominal surgery *(describe circumstances)*:

____

____

______________________ ____________
Physician's Signature *Date*

PSC Graphics (301) 443-1090 EF

PAPERWORK REDUCTION ACT STATEMENT

A Federal agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays the currently valid OMB control number. Public reporting burden for this collection of information will vary; however, we estimate an average of one hour per response, including for reviewing instructions, gathering and maintaining the necessary data, and disclosing the information. Send any comment regarding the burden estimate or any other aspect of this collection of information to the OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Respondents should be informed that the collection of information requested on this form is authorized by 42 CFR part 50, subpart B, relating to the sterilization of persons in federally assisted public health programs. The purpose of requesting this information is to ensure that individuals requesting sterilization receive information regarding the risks, benefits and consequences, and to assure the voluntary and informed consent of all persons undergoing sterilization procedures in federally assisted public health programs. Although not required, respondents are requested to supply information on their race and ethnicity. Failure to provide the other information requested on this consent form, and to sign this consent form, may result in an inability to receive sterilization procedures funded through federally assisted public health programs.

All information as to personal facts and circumstances obtained through this form will be held confidential, and not disclosed without the individual's consent, pursuant to any applicable confidentiality regulations.

Forma Aprobada: OMB No. 0937-0166
Fecha de expiración: 11/30/2009

CONSENTIMIENTO PARA LA ESTERILIZACIÓN

NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSARÁ EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

■ CONSENTIMIENTO PARA ESTERILIZACIÓN ■

Yo he solicitado y he recibido información de

____
(médico o clínica)

sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como A.F. D. C. o Medicaid, que recibo actualmente o para los cuales seré elegible.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. YO HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS.

Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que seré esterilizada/o por medio de una operación conocida como ______________________________. Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el: ______________________
(día, mes, año)

Yo, ______________________________, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada / o por ______________________________
(médico)

por el método llamado ______________________________.
Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a:

Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta Forma.

______________________________ fecha: ______________________
(firma) *(día, mes, año)*

Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo: *(Definición de raza y origen étnico)*

Origen étnico:
- ☐ Hispano o latino
- ☐ No hispano o latino

Raza (marque según aplique):
- ☐ Indígena americano o indígena de Alaska
- ☐ Asiático
- ☐ Negro o afroamericano
- ☐ Natural de Hawaii u otras islas del Pacífico
- ☐ Blanco

■ DECLARACIÓN DEL INTÉRPRETE ■

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada:

He traducido la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a él/ella la Forma de consentimiento en idioma ______________________ y le he explicado el contenido de esta forma. A mi mejor saber y entender, ella/él ha entendido esta explicación.

______________________________ ______________
(firma del intérprete) *(fecha)*

■ DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO ■

Antes de que ______________________________
(nombre de persona)

firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación ______________________________, para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento.

He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente.

Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

______________________________ ______________
(firma de la persona que obtiene el consentimiento) *(fecha)*

____
(lugar)

____
(dirección)

■ DECLARACIÓN DEL MÉDICO ■

Previamente a realizar la operación para la esterilización a ______________________________
(nombre de persona esterilizada/o)

en ______________________ . Le expliqué a él/ella los detalles de
(fecha de esterilización)

esta operación para la esterilización ______________________________, del hecho de que
(especifique tipo de operación)

es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconsejé a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente.

Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene a lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento.

(**Instrucciones para uso alternativo de párrafos finales**: Utilice el párrafo 1 que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización a menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el párrafo 2 que se presenta más adelante. Tache con una X el párrafo que no se aplique.)

(1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias (marque la casilla apropiada y escriba la información requerida):

- ☐ Parto prematuro
  Fecha prevista de parto: ______________________
- ☐ Cirugía abdominal de urgencia *(Describa las circunstancias)*:

____

____

______________________________ ______________
(firma del médico) *(fecha)*

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DECLARACIÓN SOBRE LEY DE REDUCCIÓN DE TRÁMITES

Una agencia federal no debe llevar a cabo o patrocinar la recolección de información, y el público no está obligado a responder a la misma o a facilitar la información, a no ser que dicha solicitud de información presente un número de control válido de la OMB. La carga horaria para el público que completa esta forma variará; sin embargo, se ha estimado un promedio de una hora por cada respuesta, cálculo que incluye el tiempo para revisar las instrucciones, buscar y presentar los datos exigidos y completar la forma. Para enviar sus comentarios sobre la carga horaria estimada o cualquier otro aspecto de la información requerida, escriba a OS Reports Clearance Officer, ASBTF/Budget Room 503 HHH Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Se debe informar al público que responde a esta forma que la recolección de información solicitada en la misma se autoriza en virtud de 42 CAR parte 50, subparte B, que tiene que ver con la esterilización de personas en programas de salud pública que son financiados por el gobierno federal. El propósito de la recolección de esta información es asegurar que las personas que solicitan la esterilización sean informadas sobre los riesgos, los beneficios y las consecuencias de esta operación, y para asegurar el consentimiento voluntario e informado de todas las personas que se someten al procedimiento de esterilización en programas de salud pública que reciben asistencia federal. Se pide a las personas que llenan la forma que incluyan datos sobre su raza y grupo étnico, aunque esta información no es requerida. Toda la demás información solicitada en esta forma de consentimiento es requerida. Si la persona que llena la forma no proporciona la información requerida o si no firma esta forma de consentimiento, podría resultar en que no recibiera el procedimiento de esterilización financiado por un programa de salud pública patrocinado con fondos federales.

Toda la información de datos y circunstancias personales obtenidas por medio de esta Forma son confidenciales y no se divulgarán sin el consentimiento de la persona, en conformidad con todos los reglamentos aplicables de confidencialidad.

Public Health Seattle and King County
Family Planning Program

Vasectomy Information and Consent Form

I hereby authorize the medical staff of the Public Health – Seattle & King County to provide the treatment listed below. I have been advised of:

- ❑ The nature and character of the proposed treatment;
- ❑ The anticipated results of the proposed treatment;
- ❑ The alternative forms of treatment, including non-treatment; and
- ❑ The recognized possible risks, complications, and anticipated benefits involved in the proposed treatment, and in the alternative forms of treatment including non-treatment.

Vasectomy:

It is important that you have had a preliminary visit with the physician. Our goal is for you to understand the procedure in its entirety, and to have all of your questions answered.

What happens during the surgery:
The vas deferens (vas) carries the sperm from the testes to the urethra (the tube which carries the urine from the bladder to the end of the penis). A vasectomy is the cutting and closing of this vas. The vas is cut and cauterized (burned) in the upper part of the scrotum. In this area it is just under the skin and very accessible. The procedure itself takes approximately sixty minutes and is done by injecting a local anesthetic (such as the dentist uses to fix a tooth) in the skin. A small incision or puncture is made on each side of the scrotum or just a single midline incision. The vas is identified, cut and cauterized. Usually the only discomfort is at the time of injection of the anesthetic.

The following issues should be considered:

1. It is important to refrain from aspirin or other nonsteroidal anti-inflammatory medications like ibuprofen or Naprosyn for five days preceding the procedure.
2. Please inform us if you have ever had a bleeding problem.
3. Please have a driver available.
4. Your “dressing” following the procedure is a supporter (jockstrap) and should be brought to the clinic on the day of your procedure. It also serves as a pressure dressing for a period of time following the vasectomy, usually 24-48 hours will suffice, or longer if it’s more comfortable to do so.
5. Shower or bathe on the day following the vasectomy and thereafter gently apply soap to the scrotum, rinse and blot dry avoiding rubbing. Using crushed ice in a ziploc bag or a bag of frozen peas held in place by jockey shorts over the supporter is a good way to prevent swelling. Alternating for half-hour periods off and on seems effective. Only non-aspirin pain relievers, acetaminophen preferably, should be used.
6. Neosporin or like antibiotic ointments (even plain Vaseline will work) can be used twice a day on the two wounds.
7. Use another means of birth control for 6-8 weeks post vasectomy, or until your sperm sample has been tested and shows no sperm. The sperm sample can be collected in a jar or container obtained from our office. If sperm is seen upon exam in the laboratory, protection will be necessary until a repeat test is done 6 weeks later. Some people retain sperm in their reproductive tract longer than others. This does not mean the procedure has not worked.
8. Refrain from sex for one week. Most patients prefer to have the procedure at a time when they can loaf a few days afterward. We advise you wait several days before heavy work or jumping.
9. It is important for you to ejaculate at least 12 to 20 times before your first semen test to clear out any remaining sperm in your tracts. Remember until the sperm test is negative for sperm, you can still get a woman pregnant.
10. A small amount of oozing of blood (enough to stain the dressing), some tenderness and mild swelling in the area of the incisions are not unusual and should subside by 72 hours. This should cause no alarm if there is no unusual amount of swelling of the scrotum or pain. If there is pain and swelling, or any substantial free bleeding, feel free to call the doctor at any time. If for any reason you cannot reach him or his partners please go to the closest emergency room.

11. If you have any questions about this information or other aspects of your procedure please don't hesitate to ask.
12. Most asked questions:
    - Q: Will this affect my sexual drive or ability?
      A: There is no indication that a vasectomy modifies the sexual drive in any physiological way.
    - Q: Will my semen look the same?
      A: Yes, most of the semen specimen is not made up of sperm and you can not tell the difference.
    - Q: Can the cords ever be put back together?
      A: This is possible, however, the success is variable and cannot be guaranteed in any one individual.
    - Q: Are there ever failures?
      A: Rarely. If there are more than one vas on each side, then this can be missed. This is a rare anatomical abnormality. Infrequently, a cord can reanastamose spontaneously (grow together without being attached surgically) and, again allow sperm in the semen.

- ❑ I have been told about the risks, benefits, and common problems with this surgery and of other methods of birth control. I have read and reviewed the state patient information booklet and consent, and I agree to be sterilized as I do not want more children.
- ❑ I understand that no birth control method is 100% effective and I need at least one semen test after the surgery to show there are no sperm in the semen.
- ❑ Until the semen test is negative for sperm, I understand I could still be fertile, have sperm, and could get my partner pregnant. I need the first test 6 to 8 weeks after the surgery after 12 to 20 ejaculations. If there are any sperm, I will need another test done and possibly need the surgery repeated. The best negative test is a single negative test at 12 weeks.
- ❑ I also understand even with no sperm found on the test rarely the vas deferens (tubes for sperm) can come back together even years later (1 in 1000 risk) and sperm could be released and pregnancy happen.
- ❑ I have also been told about the risks of the surgery including bleeding, infection, injury to other organs, vessels, or nerves, late complications like hematomas, granulomas, and method failure.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have had the chance to ask questions. All my questions and concerns have been answered to my satisfaction. I will indicate my informed consent for treatment and surgery with the following signature:

________________________ ____________________________________
Date Signature of Patient/Other Legally Responsible Person if Applicable

________________________ ____________________________________
Witness Interpreter

Public Health
Seattle & King County
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Place Patient Information Sticker Here
OR Name & DOB

rev: 10/23/02