# *REQUEST FOR EXAMINATION, TREATMENT AND PROVISION OR INSERTION OF CONTRACEPTIVE DRUG, DEVICE, OR METHOD*

I am asking to be examined and treated by a person authorized by _____(Name of Clinic) and I am requesting that I be given a birth control method. I have been informed about all available birth control methods. I have received, read, and understand the information on birth control methods that was given to me. I understand how to use these methods, how effective they are in preventing pregnancy, and what medical problems they might cause.

My questions about birth control have been answered. I know that I may ask a clinician (nurse, doctor, pharmacist, etc.) any other questions I have about these birth control methods. I know that the clinician cannot "guarantee" that the birth control method I choose will work all the time. There is still a small chance I could get pregnant while using any birth control method.

I have also been told about testing for sexually transmitted diseases (STDs) including HIV/AIDS. I realize that if I have tests done for sexually transmitted diseases some of my test results may need to be reported to public health agencies, as required by law.

If I am under 18 years of age, I have been encouraged to involve a parent, guardian, or other family member in my healthcare and healthcare decisions. I have received counseling on how to resist attempts of sexual coercion.

I give my permission to the employees of _____ (Name of Clinic) and others authorized by them to use information contained in my medical record for statistical and research purposes.

**I have read and understand the information above.**

Patient Signature: _____ Date: _____

**The client has been counseled, provided with the appropriate informational material, and understands the content of both.**

Counselor/Provider signature: _____ Date: _____

Print counselor/provider name: _____

Name of patient: _____ Date of Birth: _____ Chart #:_____

Interpreter: _____