

**GREEN HILLS COMMUNITY ACTION AGENCY/WOMEN'S HEALTH SERVICES
1506 OKLAHOMA AVENUE/P.O. BOX 278
TRENTON, MO 64683 (660) 359-2855**

ORAL CONTRACEPTIVE INFORMED CONSENT FORM

I have received a fact sheet containing information on the use, effectiveness, and medically recognized risks of the available birth control methods including oral contraceptives (birth control pills) and devices, such as intrauterine devices (IUD's), the diaphragm, and other contraceptive methods. I have read the fact sheet and understand it. I will read the FDA approved pill package insert that is included with each package of pills I receive.

I am voluntarily receiving oral contraceptives (birth control pills) as a method of family planning. I am aware that birth control pills are not guaranteed to be 100% effective in preventing pregnancy, and that they offer no protection against sexually transmitted diseases.

BENEFITS: It is my understanding that oral contraceptives can be 97.5% effective if used correctly all the time. I have been told that in addition to their benefits as a method of birth control, some women experience the following benefits: decreased menstrual bleeding, decreased menstrual cramps, more regular menstrual bleeding, improvement in acne, protection from some female cancers.

RISKS/SIDE EFFECTS: I am aware that while using birth control pills, I may have the following side effects: nausea, spotting between periods, depression, breast tenderness, weight gain or loss, headaches, darkening of the skin on my face, high blood pressure, acne, greater chance of some vaginal infection, changes in sex drive. Many of the minor side effects may disappear after taking the oral contraceptives for 2-3 months. I have been told that certain other drugs or medications which I might take could interact with my oral contraceptives, increasing the chance of pregnancy.

I understand that I may be responsible for any cost related to complications resulting from oral contraceptives.

In addition to the above side effects, I have been told that birth control pills may be associated with blood clots of the legs or lungs, strokes, heart attacks, gallbladder disease, liver tumor, and that these side effects may rarely result in death. The risk of heart attack or stroke may be increased by smoking more than 15 cigarettes a day or by certain medical conditions.

I have been told that in order to lessen the chance of serious problems, it is my responsibility to seek medical care if I start having any of the following symptoms: severe headaches, severe depression, chest pains (not in breast), severe pain, redness in leg, swelling, abdominal pain, blurred vision or loss of vision, yellowing of skin or eyes, breast lump, or miss a period.

I understand that I should not take birth control pills if I am pregnant.

I have been told that I should tell any clinician providing for my care that I am taking oral contraceptives.

ALTERNATIVES: Other methods of contraception have been explained to me including risks, benefits, safety and effectiveness, side effects, complications and danger signs. I have had all of my questions answered.

INSTRUCTIONS: Instructions for the use of the pills and patient labeling information have been given to me.

QUESTIONS: All of my questions about the BENEFITS, RISKS, and ALTERNATIVES of oral contraceptives have been answered to my satisfaction.

STOPPING PILLS: I have been told I have the right to stop using pills at any time. If I decide to stop, it will not affect the benefits I receive from any government program. I understand that a woman is most likely to get pregnant if she and her partner do not use any birth control method. I have been told that after stopping pills, I should use another means of birth control until I have three regular periods before I get pregnant. For most women, the risks of pregnancy are greater than the risks of using this birth control method.

YEAR ONE

CLIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

YEAR TWO

CLIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

YEAR THREE

CLIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____