WELLNESS CENTER OF DOOR COUNTY, INC.
312 N. 5th Avenue, PO Box 85,
Sturgeon Bay, WI 54235

REQUEST FOR PROVISION OF CONTRACEPTION (BIRTH CONTROL)

Patient Name____ Chart # _______________

Before you give your consent, be sure you understand both the pros and cons of using birth control. This form lists the possible problems that can occur with birth control and the danger signs you should watch for. If you have any questions we will be happy to discuss them with you. You can change your mind at any time about using birth control. Remember that your consent is entirely voluntary and you may ask for a copy of this form.

I have received a brochure containing information on the use, effectiveness and medically recognized benefits and risks of the available birth control methods and devices. I have reviewed the brochure, understand my options and have had all my questions answered. I understand that there can be no guarantee made regarding the effectiveness of the method I choose.

I wish to prevent pregnancy &/or receive other medical benefits at this time and realize that birth control methods such as the pill, patch, ring or shot provide very effective pregnancy protection if I take/use it correctly/receive it on time.

I understand that in addition to its value as a method of birth control most women experience the following benefits from using contraception:

- Predictable and regular menstrual cycles (periods)
- Decreased length of periods, menstrual cramps and blood loss
- Less iron loss (due to less blood loss)
- Less acne
- Some protection from non-cancerous breast tumors and ovarian cysts
- Some protection from ovarian and uterine lining cancer
- Decreased risk of an infection of the pelvis (pelvic inflammatory disease-PID)
- Fewer tubal/ectopic pregnancies
- **Absence of period (if on Depoprovera)**

I understand that there may be less protection from pregnancy if eat large amounts of black licorice or use other medications with my birth control. This is particularly true if I take **antibiotics**, seizure medication or St. John's Wort. I understand that I should always talk to my clinician about taking any other medications if I am using birth control.

I understand that if I see another health care provider I should always inform him/her that I am on birth control.

I understand that if I have reason to believe that I might be pregnant, I need to return to the clinic ASAP (and within 2 weeks of missing a period) for a pregnancy test & I should not stop my birth control method until I am evaluated or have a confirmed positive pregnancy test.

I understand that users of the ring, patch or pill have a slightly greater chance than non-users of developing certain serious problems that may become fatal in rare cases including:

- Blood clots in the legs that can travel to the lungs
- Stroke
- Heart attack
- Liver tumors

I understand that the chances of developing serious health problems increase over the age of 35 and/or when certain other health risks are present, such as:

- **Smoking more than 15 cigarettes/day**
- High blood pressure
- High levels of cholesterol or blood fat
- Diabetes

I understand that I may need special tests if I have certain medical conditions that could become worse while using birth control.

I understand that I may not be eligible to use certain methods of birth control if any of the following exist now or in the past, or develop in the future:

- Blood clots in the veins or arteries
- Serious liver disease
- Heart attack or certain types of strokes
- Cancer of the breast, uterus or liver
- Current or future weight over 195# (decreases birth control effectiveness **for patch users only**)

I understand that some women may also experience the following side effects/minor reactions:

- Nausea or vomiting (very rare and limited)
- Breast tenderness
- Weight gain or loss
- Spotting or break-through bleeding between periods
- Mood changes
- Changes in appetite
- Increase or decrease in sexual desire (libido)
- Spotty darkening of skin (especially if I don't use sunscreen)

I understand that if I choose to receive the shot as my method of birth control I may experience these things that are unique to Depoprovera and that there is no way to neutralize or reverse the side effects until the shot wears off 13 weeks later:

- A change in menstrual periods----in particular unpredictable spotting/bleeding during the first year of use
- Increased appetite
- **Increased risk of calcium loss and potential for bone thinning---therefore I need to consume 4-5 servings of dairy (milk, cheese, yogurt & cottage cheese) or use 1200mg calcium supplement EVERY DAY**
- Complete absence of a period which is safe as long as I'm using this method & not experiencing pregnancy symptoms
- Hair loss or increased facial hair (very rare)

I know to watch for the following danger signs and seek emergency care in the event of:

- Sharp or crushing chest pain
- Shortness of breath (not related to exercise, head or chest cold)
- Coughing up of blood
- Unusual swelling, redness, warmth, tenderness in one or both legs
- Severe stomach or abdominal pain
- Unusually heavy vaginal bleeding (saturated pad or tampon change hourly)
- Sudden severe headache especially if accompanied by vision changes OR unrelieved by typical medication used
- Yellowing of the skin or eyes (**urgent visit to your health care provider** recommended)

I also understand that I need to contact a health care provider if I develop:

- Severe or significant depression
- New lump in my breast
- Changes in vision such as blurred or double vision
- No period after having a regular period (unless on Depoprovera or using continuous method as prescribed)

I understand that I will receive the FDA approved written information pamphlet provided by the manufacturer of my chosen birth control method and will ask any questions about anything I do not understand.

I understand that using birth control does NOT protect against sexually transmitted diseases (STDs) & that unprotected sex can cause sterility for me and my partner(s). I understand that I should be using condoms and/or barrier protection for ANY form of sexual activity (vaginal, rectal or ORAL sex) even though I am using birth control.

I understand that regular check-ups are necessary while using birth control and I know when to return for follow-up care. I hereby request that a representative of the Wellness Center of Door County, Inc.. complete an evaluation and provide me with the method of birth control I desire. I understand that if I have difficulty using this method, I will call the Wellness Center and/or return to the clinic for a different method and/or discussion.

I also understand that if I interrupt my current birth control method (missed 2 or more days of pills; patch fell off or missed Depoprovera timeline for receiving next shot) and I had UNPROTECTED sex I may be able to use Emergency Contraception or the "morning after pill". I can obtain this through the Wellness Center.

Signature: ____ Date: ____________________

2/23/05