**Consent Form:**

**Complex Removal of an Copper Intrauterine Device (Cu IUD) or Levonorgestrel Intrauterine Device (LNG IUD)**

Patient details or ID label

Responsible Health Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I accept the following:**

* If you have **had sex in the last 7 days**, you must let the doctor or nurse know as there may be a possibility of pregnancy if we remove the device today.
* **Local anaesthetic** gel, spray or injection will be offered.
* **The procedure will involve** either gentle traction on the threads of the device (if we can see them) or the insertion of an instrument through the cervix (neck of the womb) to locate the device and gently remove it.
* There is a **small risk of perforation** of the uterus during the procedure. (When the instrument being used is accidently placed through the womb.) If the doctor or nurse feels this has happened, they will advise you on what to do**.**
* There is a **small risk of infection** when this procedure is done. We may offer a swab for chlamydia to be taken prior to, or at the time of the procedure, to minimise the chance of risk to future fertility and pelvic infection.
* Please tell the fitter **if you feel unwell** during the procedure, occasionally a woman feels lightheaded and rarely can have low blood pressure and pulse. This will be monitored throughout.
* Please **seek medical help** if you have any concerns after the procedure. If you notice an increased offensive discharge, pelvic pain or feel feverish this may suggest you have an infection which could need treating with anti-biotics.
* If the device is removed today and **alternative contraception** is needed, this can be discussed in the consultation.
* If we are unsuccessful at removing the device, this will be discussed with you and a plan made going forwards

Patient ID label

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Further Discussion/ Notes:**

The clinician and the patient have discussed what the procedure is likely to involve, the benefits and risks and the patient has had the opportunity to ask any questions about the procedure or raise any concerns.

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**Doctor / Nurse to sign**

* I have explained all the information in a way that the patient understands, and the patient has been given the opportunity to ask any questions.

Signed: \_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (PRINT)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient to sign**

**Would you like a copy of this form? Yes / No**

* I Understand the information that has been given to me and have had the opportunity to ask any questions. I am not aware of an allergy to local anaesthetic.

Patient’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name (PRINT) Date\_\_\_\_\_\_\_\_\_

*You have a right to change your mind at any time - even after you have signed this form*

**Interpreter** (where appropriate)

* I have interpreted the information above to the patient to the best of my ability and in a way in which I believe she can understand.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name (PRINT)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_