**Consent form:**

**Insertion of Subdermal Contraceptive Implant**

Patient details or ID label

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

**I accept the following:**

* The new implant will be **fitted by a short procedure** using a small amount of local anaesthetic injection/spray
* The implant is a **reliable method of contraception** which can last for up to 3 years but can be removed at any time
* **Fertility** will return to what it was before as soon as the implant is removed

* There may be **changes to the menstrual cycle** including intermittent bleeding, prolonged frequent bleeding, no bleeding or regular bleeding
* There may be other **hormonal side effects** such as mood swings, headaches, breast tenderness, weight changes and skin changes
* There may be **local side effects** from the implant at the insertion site such as bruising, infection, scarring, irritation and (rarely) damage to blood vessels or nerves
* The implant **may not be effective immediately** after insertion. You may need to use alternative contraception for 7 days. You will be advised of this in the consultation.
* You still need to use **condoms** if you want to prevent sexually transmitted infections
* There is a **small risk of contraceptive failure** (less than 1:1000) – no method of contraception is 100% effective
* There is a 1 in a million chance of **migration** of the implant via a blood vessel to other parts of the body e.g., heart or lungs
* There is a small **risk of deep insertion** of the implant requiring specialist removal in the future.
* It is important that women **check they can always feel the implant** and contact us if any concerns

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient to sign**

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

* I am not aware of any reason why I should not have a contraceptive implant (such as pregnancy, liver disease, breast cancer, allergies to the device or 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\_\_\_\_\_\_\_\_\_\_