**Consent form:**

**Removal of Subdermal Contraceptive Implant**

Patient details or ID label

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

**I accept the following:**

* The **procedure** will involve removing the implant using a small amount of local anaesthetic injection; a small cut will then be made over the end of the implant and the implant will be removed - possibly with the use of forceps.
* **Fertility** will return to what it was before as soon as the implant is removed, so it is important to use another method of contraception immediately if you do not wish to become pregnant.

* If the implant is **difficult to feel or seems to be pressing on a nerve or blood vessel** removal may not be possible at this appointment and you may be referred to another clinic.
* 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.

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 understand the information that has been given to me and have had the opportunity to ask any questions.

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