



COMBINED HORMONE CONSENT FORM
(ORAL CONTRACEPTIVE AND CONTRACEPTIVE PATCH, VAGINAL RING)

I, _____, hereby acknowledge that I was given an opportunity to ask questions about all forms of birth control, meaning all prescription, non-prescription, and natural methods. All of my questions were answered to my satisfaction and I understood all of those answers. I understand that no method of birth control, except abstinence, is 100% effective against pregnancy or contracting sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) infection that leads to the Acquired Immunodeficiency Syndrome (AIDS) disease.

I also acknowledge that the following benefits, risks/side effects, warning signs, alternatives, instructions, and decision to discontinue use option, regarding the birth control method, _____, were explained to me before I voluntarily decided to use this method of birth control.

BENEFITS: When the combined hormonal methods, birth control pill and contraceptive patch, are used correctly, the chance of becoming pregnant is approximately 1%. Some studies indicate the chance of becoming pregnant may increase if I weigh more than 198 pounds. I understand the chance of becoming pregnant increases if I do not use the method as instructed. Some women may experience the following benefits from using combined hormones.

- Decreased menstrual cramps
- More regular menstrual bleeding
- Less risk of acute gonococcal pelvic inflammatory disease
- Less risk of developing ovarian and/or endometrial cancer
- Less risk of developing benign breast tumors and/or ovarian cysts
- Decreased menstrual bleeding
- Decreased pain at the time of ovulation
- Improvement in acne

RISKS/SIDE EFFECTS:

Serious Risks:

- Blood clots
- Stroke or heart attacks
- Gallbladder disease
- One type of liver tumor

Minor Side Effects

- Change in menstrual pattern
- Change in weight (weight gain)
- Breast symptoms/tenderness
- Headache
- Increase in blood pressure
- Depression
- Nausea
- Skin reaction at the patch site

WARNING SIGNS: I have been told that I need to call a doctor or the family planning clinic if I have any of the following early warning signs develop:

- A** – Abdominal pain (severe)
- C** - Chest pain or shortness of breath
- H** – Headaches (severe); dizziness, weakness, numbness
- E** – Eye problems – blurred vision, flashing lights, or blindness; speech problems
- S** – Severe leg pain (calf or thigh)

ALTERNATIVES: I have received written information about other methods of birth control and I choose the _____.

INSTRUCTIONS:

- Birth Control Pill: I am aware that I should use condoms or another contraceptive method for the first month after I first start to take birth control pills, to keep from getting pregnant. I have been told that I need to take my pill every day at the same time. Failure to do so increases the risk of pregnancy.
- Contraceptive Patch: I am aware that I need to apply the patch on the same day of the week for three consecutive weeks. I do not apply a patch during the fourth week. On the day after week four ends, I begin a new cycle by applying a new patch. I have been told and understand what to do if I forget to apply my patch.
- Vaginal Ring: I am aware that I need to insert the ring and leave in the vagina for three weeks. At the beginning of the fourth week I remove the ring and leave out for a week. I have been told and understand what to do if I forget to insert or remove the ring.

DECISION TO DISCONTINUE USE: I understand that I may discontinue use of the combined hormone method at any time. I understand that I should use another method of birth control if I do not desire to become pregnant. If I wish to become pregnant, I have been told I may choose to use another means of birth control until I have had two to three regular periods before attempting to become pregnant so the date of delivery might be more accurately determined. I understand there may be some delay in becoming pregnant after I stop using birth control.

I hereby release the South Dakota Department of Health, the South Dakota Family Planning Program, and any of its employees or agents, from and against any and all claims, damages, or liabilities which I may have against them as a result of my receiving birth control and related medical services, supplies, and/or procedures.

Client Signature

(date)

Witness Signature

(date)