PLANNED PARENTHOOD OF SOUTHWEST & CENTRAL FLORIDA

MANATEE - SARASOTA - TAMPA - FT. MYERS - LAKELAND - WINTER HAVEN - PINELLAS
(941) 567-3800 (941) 953-4060 (813) 980-3555 (239) 481-9999 (863) 665-5735 (863) 293-7494 (727) 898-8199

PUT LABEL HERE

Last/ First Name: _____

Chart#: _____

D.O.B.:_____

REQUEST FOR SURGERY OR SPECIAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I will be given information about the test(s), treatments, service(s)/procedure(s)/ surgery to be provided, including the benefits, risks, possible problems/complications and alternate choices. I was given *written patient information* and/or a copy of the Planned Parenthood Client Information for Informed Consent sheet. It was reviewed with me.

I understand that with any service/procedure/surgery, there is also the possibility of side effects. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee about the results from this service/procedure/surgery has been given to me. I know that it is my choice whether or not to have this service/procedure/surgery. I know that I can change my mind about receiving this service at Planned Parenthood at any time.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I will be told how to get care in case of an emergency.

If there is an unexpected complication during the service/procedure/surgery, I request and authorize the clinician and authorized Planned Parenthood staff to do whatever is necessary to preserve my health and welfare.

In the event I need more pain medication to safely continue or complete the procedure, I request and authorize Planned Parenthood staff to give me medications they believe necessary. This may include medications to reduce pain and/or anxiety. I understand every medication carries a small risk. I understand the clinician will only use medications if s/he believes it is clinically indicated.

Request for Surgery or Special Procedure
I-B-2b
Revised September 2012

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D.O.B.:_____

I request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it) and perform the following service(s)/ procedure(s)/surgery:

- □ In-Clinic Suction Abortion – Removal of uterine pregnancy less than 13 weeks gestational age by mechanical method.
- □ In-Clinic Dilation & Evacuation (D&E) Abortion – Removal of uterine pregnancy at 13 weeks or greater gestational age by mechanical method.
- □ Osmotic Dilator Insertion prior to Surgical Abortion – Short thin rods placed in the cervix (opening of uterus) to stretch the opening before the abortion procedure.
- □ The Abortion Pill – Prescription medicine taken to stop pregnancy development and cause passage of uterine pregnancy up to 9 weeks gestational age.
- □ Uterine Aspiration – Removal of blood or remaining pregnancy tissue from uterus following abortion.
- □ Treatment of Miscarriage with a Suction Procedure – Removal of remaining pregnancy tissue from uterus following an early pregnancy loss.
- □ Treatment of Miscarriage with Abortion Pill – Prescription medicine taken to cause passage of pregnancy tissue following an early pregnancy loss.
- □ Colposcopy – Use of microscope to look for abnormal cells on cervix (opening of uterus).
- □ Cervical Biopsy and Endocervical Sampling (ECS) – Removal of small piece(s) of tissue on cervix to check for abnormalities.
- □ Endometrial Biopsy – Removal of cells from lining of uterus to check for abnormalities.
- □ Vulvar Biopsy – Removal of small piece of tissue from the lips of vagina to check for abnormalities.
- □ Cryotherapy of Cervix – Freezing of top layer of cervix (opening of uterus) to treat abnormal cells.
- □ LEEP – A small electrical wire loop used to remove abnormal tissue from the cervix.
- □ IUC Insertion – Placement of □ Mirena □ Paragard into uterus to prevent pregnancy.
- □ Contraceptive Implant Insertion – After a shot of numbing medicine, birth control device (flexible 1 ½" rod) is placed under skin of upper arm to prevent pregnancy.
- □ Contraceptive Implant Removal – After a shot of numbing medicine, small cut is made in skin and the birth control device is removed through it.
- □ Prenatal Care – Healthcare provided during pregnancy.
- □ Hysteroscopic Tubal Sterilization (Essure®) – A method of permanent birth control. A tiny device, called a microinsert, is used to close the opening of each of the fallopian tubes (the tubes that carry the eggs from the ovaries to the uterus).
- □ Vasectomy – A method of permanent birth control. After a shot of numbing medicine, the vas deferens are cut or blocked.
- □ Cervical polyp removal – Removal of growth at opening of the uterus. The growth will be sent to the laboratory for testing.

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D.O.B.:_____

- ☐ Fine Needle Aspiration of Breast (FNA) – Use of a thin needle to remove cells or fluid fluid from a lump in the breast. The cells or fluid will be sent to the laboratory for testing.
- ☐ Breast Cyst Aspiration – Use of a thin needle to remove the fluid from a fluid filled lump in the breast.
- ☐ Treatment of Bartholin's Duct Abscess (I & D) – Small cut made to infected area to drain fluid from it.
- ☐ Skin Biopsy – Removal of a very small piece of skin to check for disease or remove the problem.
- ☐ Other: _____

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

Please note that Planned Parenthood of Southwest and Central Florida is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

I understand that confidentiality will be maintained as described in Planned Parenthood of Southwest and Central Florida, Inc.'s *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby acknowledge receipt of Planned Parenthood of Southwest and Central Florida, Inc.'s notice of health information privacy practices.

_____ _____
Signature of Patient Date

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

_____ _____
Signature of Witness Date

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW.

_____ _____
Signature of any other person consenting Date
Relationship to patient _____

I witness the fact that the patient's legal guardian (or person consenting in her/his behalf) received the above mentioned information and said she/he read and understood same.

_____ _____
Signature of Witness Date