

## Pre Insertion Section

Patient to tick boxes

<b>Benefits and risks</b>	<p>I have discussed the benefits, risks and side effects of using Implanon® with my doctor. Side effects may include:</p> <ul style="list-style-type: none"> <li>irregular bleeding, no bleeding, headaches, weight gain and breast symptoms</li> <li>bruising and discomfort for up to one week after insertion</li> <li>the possibility of allergic reactions</li> <li>the implant moving from its original position, which could make removal more difficult.</li> </ul>	<input type="checkbox"/>
<b>Effectiveness of contraception</b>	I am aware of the effectiveness of Implanon® as well as its relative effectiveness compared with other birth control methods. I am aware no birth control method is completely reliable so I could have a small chance of becoming pregnant	<input type="checkbox"/>
<b>Removal after three years</b>	I understand that the Implanon® implant must be removed by three years since leaving it in place for longer may increase the chances of an ectopic pregnancy (pregnancy in the tube). I am aware it is my responsibility to arrange removal	<input type="checkbox"/>
<b>Scarring</b>	The insertion and removal of the Implant may leave a small scar on the skin. I am aware that some people are predisposed to develop a thickened scar. A larger scar is likely if the Implanon® implant is difficult to remove	<input type="checkbox"/>
<b>Insertion and removal</b>	I understand that to reduce discomfort, my doctor will use a local anaesthetic when inserting and removing the Implanon® implant	<input type="checkbox"/>
<b>Allergic reactions</b>	I have advised my doctor of allergies known to me, especially allergies to a local anaesthetic, sex hormones or plastics	<input type="checkbox"/>
<b>Acknowledgement</b>	I have understood the information concerning Implanon®. I will contact my doctor should I require further advice	<input type="checkbox"/>
<b>Interactions</b>	I understand that I must advise my doctor of any medication I am taking, as these can reduce the effectiveness of Implanon®	<input type="checkbox"/>

Based on the information above, I Test Test willingly consent for my doctor to insert an Implanon® implant for use as a contraceptive in my Left/ Right arm. By ticking off each of the items above, I acknowledge that these are understood by me and have been discussed with my doctor.

Signed by patient \_\_\_\_\_ Date 29/05/2019

## Post Insertion Section

### Outcome

<ol style="list-style-type: none"> <li>I can feel the inserted implant.</li> <li>I have a copy of the Consumer Medicine Information</li> <li>I should return for a check of my blood pressure in 3 months and have an annual check while the implant is in my arm.</li> <li>I need to have the implant removed in 3 years time.</li> </ol>	<p>_____ Date <u>  /  /  </u></p> <p>Signed by Patient</p> <p>_____ Date <u>  /  /  </u></p> <p>Signed by Doctor</p>
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