

## CONSENT FOR IUD INSERTION/REMOVAL

PLACE C LABEL HERE

Name of IUD: \_\_\_\_\_

I have requested and received information on the Intrauterine Device (IUD) and have chosen to use this method of contraception. I have been counseled on the advantages and disadvantages of the IUD method and have read the FPEM-10 handout as well as the manufacturer's patient information brochure. I have had an opportunity to have all my questions answered and understand that the IUD can be placed when pregnancy can be ruled out. I also understand that the IUD does not protect me from HIV or any sexually transmitted infection and have been advised to use condoms to decrease the risk of infections. It is my responsibility to report any danger signs to my physician or clinic, and to obtain a Pap smear and/or pelvic exam (if either indicated) on a yearly basis.

### Benefits/Advantages

1. Very effective in preventing pregnancy
2. Easily reversible
3. Offers contraceptive "privacy"
4. Can be used by women who cannot use estrogen due to medical problems
5. Requires very little motivation

### Risks/Disadvantages

1. May cause increase bleeding
2. May cause increase cramps
3. Must check strings each month
4. Offers no protection against HIV or STD infections
5. Insertion may be uncomfortable

I hereby consent to the insertion of the \_\_\_\_\_ IUD and understand that it is effective until \_\_\_\_\_ at which time I must have it removed. I have been instructed that the use of Aleve, Motrin, or Advil may help reduce my menstrual cramping.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Professional Obtaining Consent

## CONSENT FOR THE REMOVAL OF THE IUD

I have asked to have my IUD removed and understand that the procedure is best done during my menstrual period. I am aware that once the IUD is removed, I will need another method of contraception unless I am planning a pregnancy.

I have had an opportunity to discuss my questions and concerns and after doing so give my consent for the IUD removal.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Professional Obtaining Consent