Counselling Form—IUCD

Name: _____ D.O.B. ____/____/____

Current Contraception: _____ LMP: ____/____/____

Last Sexual Intercourse: _____

Obstetric History: Pregnancies: _____ Mode of Delivery: _____

Tick if any apply: Ectopic ☐ Molar ☐

Gynae History: Previous pelvic Inf: ☐ Pelvic Surgery: ☐

Irregular PV bleeding ☐ Fibroid Uterus: ☐

Last smear: _____

Medical History: Active Liver Disease: ☐ Breast Cancer Current ☐ Past 3 Years: ☐

Valvular Heart disease/endocarditis/VSD ☐

Current Medications: _____

Discuss Mode of Actions ☐ Discussed Side Effects & Risks: ☐

- ☐ • Irregular Bleeding
- ☐ • Failure of insertion
- ☐ • Failure rate 1/1000
- ☐ • Expulsion
- ☐ • Perforation
- ☐ • Risk of ectopic
- ☐ • Infection
- ☐ • Pelvic pain

STI Risk: High ☐ Low ☐

Discussed: ☐

Assessed: ☐

High Risk -
< 25 yo and sexually active
> 25 yo with:
1. *a new partner in the past year*
2. *>1 new partner in the past year*
3. *partner had >1 partner in past year*

Leaflet Given: Yes ☐ No ☐

Patient Consent Form—Intrauterine Device Insertion

Patient Name: _____

Procedure: Insertion of Intrauterine device

Device Name: _____

Patient Consent

I confirm that the information given by me is correct.
I have read the information leaflet on intrauterine devices.
The risks and side effects of the procedure and the device have been explained to me.
I understand the risks including perforation, expulsion, failure of insertion, failure of device, irregular bleeding, infection and pelvic pain.
I agree to the above procedure.

Signed_____ Date_____