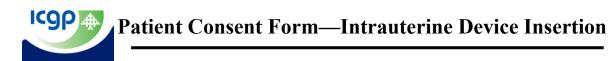


Counselling Form—IUCD

Name:		D.O.B		
Current Contraception:		LMP:	/ /	
Last Sexual Intercourse:		_		
Obstetric History: Pregnancie	es:	Mode of Delivery:	<u>. </u>	
Tick if any	apply: Ectopic	Molar		
Gynae History: Previ	ous pelvic Inf:	Pelvic Surgery:	: 🔲	
Irreg	ular 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	s & Risks:		
• Irregular Bleeding • Failure of insertion • Failure rate 1/1000				
• Expulsion • Perforation • Risk of ectopic				
• Infection	• Pelvic pain			
STI Risk: High Low	High Risk - < 25 yo and sex	ually active		
Discussed:	> 25 yo with:	·		
Assessed:	2. >1 new partn	r in the past year ver in the past year >1 partner in past ye	o av	
	-	- 1 pariner in pasi ye	cui	
Leaflet Given: Yes	No			



Patient Name:	
Procedure: Insertion of Intrauterine device)
Device Name:	
Patient Consent I confirm that the information given by me I have read the information leaflet on intrat The risks and side effects of the procedure I understand the risks including perforation irregular bleeding, infection and pelvic pair I agree to the above procedure.	and the device have been explained to me. a, expulsion, failure of insertion, failure of device,
Signed	Date