



## Counselling Form—Subdermal Implant

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Name: \_\_\_\_\_ D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
GP: \_\_\_\_\_

Current Contraception: \_\_\_\_\_ LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last Sexual Intercourse: \_\_\_\_\_

Gynae History: Last smear: \_\_\_\_\_  
Irregular PV bleeding: \_\_\_\_\_  
Medical History: Epilpesy \_\_\_\_\_ Regular Meds: \_\_\_\_\_  
Active Liver Disease: \_\_\_\_\_ Allergies: \_\_\_\_\_

Mode of action discussed: \_\_\_\_\_  
Handedness documented: \_\_\_\_\_  
Timing/Method of insertion discussed: \_\_\_\_\_

### Discuss Risks / S/E :

- Irregular Bleeding
- Progestogenic S/E
- Infection at the site
- Failure Rate 1:2000
- Scar/Breakage
- Migration
- Requires surgical removal.
- Scar after removal

STI Risk: Discussed: Assessed:

Leaflet Given: Yes No



## Patient Consent Form—Implant Insertion

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Patient Name: \_\_\_\_\_

Procedure Name: Subdermal Implant Insertion

### Patient Consent

I confirm that the information given by me is correct.

I have read the information leaflet on subdermal implants.

The risks and side effects of the procedure and the device have been explained to me.

I understand there is a risk of scarring or keloid scar formation.

I understand that removal of the device will involve a surgical procedure and may cause a scar.

I agree to the procedure; Subdermal Implant Insertion.

Signed \_\_\_\_\_

Date \_\_\_\_\_