

Rx# _____

XYZ PHARMACY
Emergency Contraceptive Pills (ECPs) Informed Consent and Services

Name _____ Birthdate _____

Address _____ Phone _____

First day of last normal menstrual period ___/___/___ Date of last unprotected intercourse ___/___/___ Time ____

(If more than one exposure, give date and time of initial exposure) _____

Before giving your consent, be sure that you understand both the pros and cons of Emergency Contraceptive Pills (ECPs). If you have any questions, we will be happy to discuss them with you. Do not sign your name at the end of the form until you have read and understood each statement and the pharmacist has answered your questions and can witness your signature. This information is confidential.

I understand that:

- ECPs contain hormones that act to prevent pregnancy. These pills are taken after having unprotected sex (sex without birth control or a birth control failure). They are to be used as an emergency treatment only and not as a routine method of contraception.
- ECPs work by preventing or delaying the release of an egg from the ovary, preventing fertilization, or causing changes in the lining of the uterus that may prevent implantation of a fertilized egg. I understand that if I am already pregnant, ECPs will not stop or interfere with the pregnancy.
- ECP treatment should be started within 3 days (72 hours) of unprotected sex.
- ECPs are not 100 percent effective.
- Reactions to the pills may include: nausea and vomiting, fatigue, dizziness, breast tenderness, early or late menstrual period.
- I should see a clinician if I do not have a normal period in 3 weeks.
- I should use condoms, spermicides, or a diaphragm, or continue taking birth control pills to prevent pregnancy if I have sex before my next period. After that, I should continue to use a method of contraception.
- ECPs will not protect me from or treat sexually transmitted diseases and I should seek diagnosis and treatment if I am concerned about this.
- I understand I should ask questions about anything I do not understand and that a pharmacist is available to answer my questions.
- I understand that it maybe useful to share this treatment information with my regular health care provider. Therefore, I request and authorize the release of this information to the following designated provider.

Yes _____ No _____ Designated Provider's Name _____

Patient's Signature _____ Date _____

Witness's Signature _____ Date _____

Rx Plan B take 1 tablet p.o. now and in 12 hours Pharmacist's Signature _____

___ instruction sheet/package insert ___ STIs, contraceptive methods information

___ Referral made to _____