INTRAUTERINE DEVICE (IUD) REMOVAL CONSENT

I am requesting to have my intrauterine device (IUD) taken out today.

Please initial:

_____ I have been informed and understand that I may become pregnant right after the IUD is taken out. If I do not want to get pregnant after the IUD is removed, I may have a new IUD put in today or choose a different method of birth control to start today.

_____ I understand that if the provider is unable to remove my IUD, I may need an ultrasound to confirm the location of the IUD and remove the device using another method. Sometimes, if the strings cannot be found or the device is in the wrong location, it may need to be removed under direct visualization using a camera inserted into my cervix and uterus. This procedure may be done in the office or in an operating room.

_____ I understand that I may have some bleeding, cramping, or pain with the IUD removal procedure, and it may continue for a short time afterward. I may take ibuprofen to relieve the cramping or pain.

_____ I have read and understand this form and would like to proceed with having my IUD removed today.

_____ _____/_____/_____

Patient Name Date

_____

Patient/Health Care Agent/Guardian/Relative Signature

_____

Physician Signature