NEXPLANON INSERTION CONSENT

I am requesting to have a contraceptive implant (Nexplanon) placed today to provide me with birth control.

Please initial:

_____ I understand that there are many birth control methods and that each has its own benefits, risks, and potential side effects.

_____ I understand that the insertion of Nexplanon requires a surgical procedure performed by a healthcare provider who is trained on the use of this product.

_____ I understand that Nexplanon is a contraceptive implant that releases a hormone (etonogestrel) to prevent pregnancy, but no contraceptive method is 100% effective.

_____ I understand that Nexplanon helps to keep me from getting pregnant but does not protect me against HIV infection (the virus that causes AIDS) or other sexually transmitted diseases.

_____ I understand that Nexplanon is placed just under my skin on the inside of my upper arm during a procedure done in my healthcare provider's office. There is a slight risk of getting a scar or an infection from this procedure. Nexplanon should not be deeply inserted. An implant that is inserted deeply may have been placed in muscle tissue or, in rare instances, a blood vessel. A deep insertion may cause the implant to move beyond the implant site.

_____ I understand that menstrual bleeding patterns may change while using Nexplanon. My bleeding may be irregular, lighter or heavier, continuous or my bleeding may completely stop. If I think I am pregnant, I should contact my healthcare provider as soon as possible.

_____ I understand that Nexplanon must be removed at the end of three years, but it can be removed earlier if I want. Removal is usually a minor procedure in the office. If Nexplanon was inserted deeply, the removal may be more difficult or, in rare cases, impossible. Difficult removals may cause pain and scarring and may result in injury to nerves and blood vessels.

_____ I have read and understand this form and would like to proceed with placement of a contraceptive implant (Nexplanon) today.

_____ _____/_____/_____

Patient Name Date

_____

Patient/Health Care Agent/Guardian/Relative Signature

_____

Physician Signature