GEORGIA DEPARTMENT OF PUBLIC HEALTH

Family Planning Program Services Manual

2024

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PURPOSE OF MANUAL

The Family Planning Program (FPP) Services Manual is a guide for public health programs who deliver family planning services using Temporary Assistance to Needy Families (TANF) funds. Providers of family planning services who are reimbursed by Title XIX (Medicaid) must follow policies and procedures as established by the Georgia Department of Community Health Medicaid Program in the Georgia Medicaid Provider Procedures Manual. The most current version of the Medicaid manual can be found under Provider Manuals (see link for Family Planning Services) on GA Medicaid Management Information System web portal (https://www.mmis.georgia.gov).

Introduction

Program Overview

The Georgia Department of Public Health (GDPH) is committed to providing accessible, affordable and high-quality family planning services across the State of Georgia in an effort to contribute to the following TANF goals:

- Assist in preventing out-of-wedlock pregnancies
- Assist individuals who wish to determine the spacing of their children

Program Goal

The goal of the FPP is to improve pregnancy planning and spacing and prevent unintended pregnancies.

The ***core services the FPP provides*** include the following:

- Provision of effective contraceptive methods
- Focused health history as pertinent to dispensing contraceptives
- Focused women's health exam, if applicable, to dispensing contraceptives
- Counseling and education
- Laboratory testing for STDs
- Referral for additional services as needed

Program Principles include the following:

- Provide quality family planning services as outlined in the most current publication of *Providing Quality Family Planning Services*: *Recommendations of the CDC and the U.S. Office of Population Affairs" MMWR 2014: 63, No. 4* (http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf)
- Provide a broad range of acceptable and highly effective family planning methods
- Implement management and decision-making through performance measures and accountability for outcomes
- Provide referral for HIV care, mental health, substance abuse, and other needed services
- Incorporate electronic technologies, such as electronic health records
- Collect data for use in monitoring performance and improving family planning services
- Improve service delivery through translation into practice of research outcomes that focus on family planning and related population issues
- Encourage vaccination of patients against vaccine preventable diseases
- Establishment of fee collection and billing systems to maximize reimbursement for services provided and increase sustainability of the family planning program

SECTION I ADMINISTRATIVE

Purpose

This section assists the Family Planning Program (FPP) clinics in conducting administrative activities including, but not limited to, assuring patient access to services and managing patient records.

The **outcome measures** of FPP are the following:

- Reduce unintended pregnancies
- Improve pregnancy planning and spacing
- Improve pregnancy outcomes
- Reduce teen pregnancies

For FPP **performance measures**, refer to the current version of the TANF Public Health Master Agreement Annex (GIA 401) located on PHIL 2.0 http://www.dphphil.org

Organizational Structure

State Health Office

Program funds are distributed to the 18 District Health Offices in Georgia to provide Family Planning services to the local community. The State Family Planning staff provides the following services for the district health offices and county health departments:

- Technical assistance
- Development of manuals, policies, and protocol
- Staff training related to family planning
- Quality assurance and quality improvement activities utilizing standardized procedures
- Annual site visits

District Health Office

The 18 District Health Offices serve as a liaison between the State Family Planning Office and the county health departments. They provide the following services:

- Interpretation of policies and procedures
- Coordination of training
- Management of funding for supplies and patient benefits
- Coordination of quality assurance and quality improvement activities utilizing standardized procedures
- Provision of staff to assist in the provision of family planning services

County Health Departments

The county health departments and service delivery sites within the counties provide comprehensive family planning program services for females of reproductive age with a priority focus on low-income females. Family planning services are well integrated with numerous other health department services (e.g., immunizations, referrals for prenatal services, sexually transmitted infection services and HIV testing) to improve the comprehensiveness of the health care provided. Public health family planning service providers in Georgia include the following:

- Expanded role nurses: registered nurses (RN) with an expanded scope of practice who are trained and permitted by State-specific regulations to function under nurse protocol
- Advanced practice registered nurses (APRNs), including nurse practitioners and nurse midwives
- Physicians
- Public Health Nurses
- Health Educators
- Counselors

Additional information about the Family Planning Program can be found at:
https://dph.georgia.gov/georgia-family-planning

Chapter 1 Patient Access

Patient Access

The FPP clinic must ensure that patients are provided services in a timely and nondiscriminatory manner. The FPP clinic must ensure the following:

- Services are made available on a walk-in basis (as staffing and patient service needs allow) and through a scheduled appointment system.
- Scheduled appointments are available within two weeks of appointment request.
- Adolescents are given priority as walk-ins or for appointments.
- Qualified staff assess and prioritize patients' needs.
- Every effort is made to provide a method of contraception to each patient who requests it.
- Provide contraceptive methods to women in need (at or below 200% FPL) based on a sliding fee system.
- Family Planning patients of reproductive age must have access to **ALL** available methods of contraception through the formulary, including Long-Acting Reversible Contraceptives (LARCs), to comply with TANF requirements of comprehensive family planning services.
- Contraceptive methods should not be called into the pharmacy, regardless of insurance or Medicaid coverage, unless the method of choice is not available through the DPH pharmacy or manufacturer, or shipping or shortage issues impact availability.
- Availability of referral resources for individuals that cannot be served due to medical conditions.

Chapter 2 Patient Rights

Confidentiality

All Family Planning clinics must be in compliance with the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) established standards for the protection of patient privacy.

Freedom of Choice

- Patients have the freedom to choose family planning providers and contraceptive method, including no method or changing from one method to another, without coercion or intimidation.
- Acceptance of family planning services must not be a prerequisite to eligibility for or receipt of any other service or assistance.
- Medicaid patients are free to receive services from any Medicaid-enrolled family planning provider, even in managed care areas.
- Personnel must be informed that they may be subject to prosecution under Federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure [Section 205 of Public Law 94-63].

Chapter 3 Abuse and Neglect

Child Abuse Reporting

The FPP follows the most current version of DPH's Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel. As mandated reporters, public health employees are required to report suspected child abuse which includes but is not limited to physical abuse; neglect, emotional abuse, or sexual exploitation (O.C.G.A. § 19-7-5(b). FPP personnel are required to have training in recognizing and reporting child abuse at their initial orientation as well as ongoing periodic training.
Mandatory Reporting of Suspected Child Abuse Guidelines January 2023.pdf

Human Trafficking

All nurses working in family planning clinics will complete required training to increase awareness of suspected victims of human trafficking. See DPH Policy and Procedure Manual for Public Health Training.

Mandatory Reporting of Intentional Injuries and Confidentiality

If a health care provider has cause to believe that a patient has had physical injury or injuries inflicted upon him or her other than by accidental means, then O. C. G. A. § 31-7-9 requires the provider to report it. The provider should adhere to local district policy processes for reporting suspected cases of intentional injury. For more information about intentional injury, including intimate partner violence, sexual violence, and child abuse, visit:
https://www.cdc.gov/injury/index.html

Intimate Partner Violence (IPV)

The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. Women should be asked about safety within their relationship including physical, emotional, and sexual violence and coercion, at least *annually,* and with each new partner. Screening should only be done if a woman is alone or accompanied only by an infant. The presence of friends or family members during screening could lead to danger for the patient. Questions should be asked in a non-judgmental, normalizing way. Those who are experiencing partner violence should be referred to local resources. If the patient is under 18 years of age, then consult legal counsel for possible reporting as child abuse and follow mandatory reporting guidelines.
Additional information may be obtained at the following link:
https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

Referral options

If a revelation of abuse is made, refer the patient to a domestic violence program. Call the GA Domestic Violence Hotline which is **1-800-33-HAVEN (1.800.334.2836)**. Local shelters can be found on the Georgia Coalition Against Domestic Violence's website: http://gcadv.org/.
Mandated reports can be made by contacting the Department of Family and Children Services' centralized intake line, which is available 24/7 by calling **1-855-GACHILD (1-855-422-4453).**

Mandatory reporting training and online reporting can also be accessed at https://oca.georgia.gov/training/mandated-reporting.

Chapter 4 Training

Training requirements include the initial and annual trainings that nurses must complete to demonstrate that they are adequately trained to provide the services delineated in the Women's Health Protocols as permitted by nurse protocol legislation (O. C. G. A. § 43-34-23). DPH required trainings are outlined in the Policy and Procedure Manual for Public Health Nurse Training.

Districts should have the following in place:

- A mechanism to provide orientation to new employees and annual training updates to current employees.
- Documentation that tracks the completion of staff required trainings and a process for assuring documentation is available for review upon request.

Chapter 5 Quality Assurance

Patient Feedback

Districts may choose to implement patient satisfaction surveys as part of their QA/QI process. However, patient satisfaction surveys are not a requirement of the Family Planning Program. Optional patient satisfaction surveys and associated corrective action plans should be maintained locally and per district policy.

Virtual and Face to Face meetings

Frequent exchange of information through the Women's Health Coordinators in the health districts helps assure program uniformity is maintained and nursing staff are informed of up-to-date practices for delivering family planning services. This is accomplished through quarterly, virtual TEAMS calls, at least one face-to-face meeting per year (funding permitting), , quarterly program reports, and the provision of ongoing technical assistance and training as needed.

Family Planning Site Visit and Monitoring Review

The site review process is a continuous process between the FPP office and family planning clinics in the 18 Health Districts of Georgia. Every year, several health districts are selected for a site visit which includes a combination of on-site and remote reviews by a multidisciplinary state team. District administrative, clinical, and fiscal staff will be notified of the scheduled dates in advance of the visit. Site review agenda and evaluation tools will be shared in advance. Methods used for evaluation include staff interviews, record reviews, policy reviews, patient satisfaction surveys and possible clinic tours. An exit conference with appropriate staff will be conducted prior to the end of the visit. A written report of findings will be sent to the district, and the district will be responsible for submitting a plan of action to the FPP after receiving the site visit report. A specific timeline for site visit activities will be provided to the district.

Family Planning Program Record Review Guidelines

Clinical record reviews are one of the measures used as part of a system to review and strengthen the quality of family planning services. Record reviews provide essential feedback to providers on their quality of care and can help determine if services are being provided in accordance with standards, policies, procedures, and protocols. Other quality improvement measures include patient feedback, facility audit, direct observation during a patient encounter, and interviews with healthcare providers.

The goal of record reviews is to maintain and improve the quality of care by assuring service is provided in accordance with current Nurse Protocols for Women's Health and *Providing Quality Family Planning Services*: Recommendations of the CDC and the U.S. Office of Population Affairs.

Women's Health Coordinator Roles and Responsibilities

In addition to managing the record review process in the district, the Women's Health Coordinator (WHC) or designee is responsible for ensuring the following:

- There is a written district policy/procedure for record reviews of FP records. The policy/procedure must include: (1) a schedule for review of RN and APRN FP records, (2) who will provide the reviews and (3) process for selecting records for review.
- Records for each clinician will be reviewed annually (see guidance below).
- Record reviews will be performed in compliance with the site visit tools provided by the Office of Women's health ahead of the annual site visit.
- The review of Family Planning records will be performed per the guidance of this manual and the local written district policy/procedure. The FP Audit Tool for record review (Appendix A) may be used as a resource. The district record review policy should include requirements for select record review by delegating physician.
- The Record Review Tool (see Appendix A) is completed, reviewed, and signed by the clinician and delegating MD. The delegating MD must review all records chosen for review where protocol was not followed (e.g., contraceptives were inappropriately dispensed).
- If applicable, the Record Review Improvement Plan is completed with recommendations.
- Results of Record Review and Improvement Plan are discussed with the ERN or APRN whose records were reviewed.
- The Record Review Improvement Plan is reviewed and signed by the District Nursing Director or designee.
- Record Review Tools and Record Review Improvement Plans are maintained and available for review during site visits or at the request of the FPP.

Method of Selection of Records

A district designee (e.g., District Nursing Director or Women's Health Coordinator) is responsible for obtaining a random sample of patient records to review for each ERN and APRN per year. A **minimum of two (2)** Family Planning records should be reviewed annually for each ERN and

APRN who provide family planning services. Records reviewed should represent a variety of services, including physical exams, problem visits, and LARC insertions and/or removals.

Chapter 6 Data Collection and Required Reporting

Patient Encounter Data

FPP providers are required to submit encounter data for every patient served in a FPP clinic. Providers enter Family Planning Encounter data in the data management system or by the automated EMR system. (Appendix B). This data is used for the quarterly and annual TANF Report and for other reports that provide valuable data for measuring and projecting service utilization and analysis of trends. FPP providers are responsible for maintaining statistical and management information systems that are compatible with accurate reporting of contract performance (e.g., unduplicated medical users and tracking progress toward contract objectives). Data should be transmitted electronically to the State monthly and is due between the 1st and 14th of each month.

Aggregate patient data is submitted annually by the FPP to the GA Department of Human Services (DHS), DFCS TANF program. Types of patient data include age, race, ethnicity, gender, family income, and contraceptive methods. FPP provider revenue data, number of medical encounters and the number of clinical staff providing family planning services are also reported.

The following is a schedule of district reports due to the state throughout the year.

Annually

- Annual chart review reports as described in the DPH Family Planning Manual and Master Agreement Annex.
- Districts must update their clinic addresses and identify clinics that are active/inactive using the survey link provided by the Family Planning Program.

Quarterly

- Submit District contraceptive and feminine hygiene inventory reports.
- Submit program income from previous quarter.
- Submit online Family Planning Quarterly Survey.
- Transmit family planning data through the district electronic record system by the 10th of each month.

Due dates for quarterly reports/surveys are as follows:

- 1st quarter (July-September) by **October 15**
- 2nd quarter (October-December) by **January 15**
- 3rd quarter (January-March) by **April 15**
- 4th quarter (April-June) by **July 15**

Ongoing

Districts must inform the State Office of Women's Health immediately regarding any clinic closures or staff changes in Women's Health leadership roles.

Financial Reporting (Program Income)

All Funding will be allocated in accordance with the approved method outlined in the programmatic Annex numbers 086, 291 and 401.

The FPP is a multifaceted budget that requires the collection of fee income to ensure sustainability. All fee income generated under the Family Planning Program are to be retained and used in the program as prescribed in the program annex. The term “program income” applies to fee income generated by the program funded through federal awards. Any portion of the fee income meeting the description of program income should be accounted for in accordance with DPH program income policy.

SECTION II: CLINICAL SERVICES

- Family planning clinical staff paid 100% with TANF funds must not bill Medicaid for services. Clinical staff whose salaries are split between TANF funding and other fund sources may bill Medicaid for services if the percent of salary covered by another fund source is equal to or greater than the average percent of the district family planning caseload covered by Medicaid, in accordance with TANF GIA Annex #401. For example, if the district's average percent covered by Medicaid is 37%, a salary split 63% TANF funds and 37% county funds could bill Medicaid for services.
- Provide contraceptive methods to women in need (at or below 200% FPL) based on a sliding fee system.
- Family Planning patients of reproductive age must have access to **ALL** available methods of contraception through the formulary, including LARCs, to comply with TANF requirements to provide comprehensive family planning services.
- Family planning funds must not be used to pay for sterilization.

Chapter 7 Patient Fee Collection

Purpose

To implement a fee collection system that complies with federal and state guidelines, maximizes resources, and is sensitive to the needs of the patient.

Financial Accountability

The process of determining the income level, family size, and discount group is typically done during the early stages of the patient's clinic visit. Usually, the type of visit will be known upon the patient's arrival at the clinic.

Family planning clinical staff paid 100% with TANF funds must not bill Medicaid for services. Clinical staff whose salaries are split between TANF funding and other fund sources may bill Medicaid for services if the percent of salary covered by another fund source is equal to or greater than the average percent of the district family planning caseload covered by Medicaid, in accordance with TANF GIA Annex (#401). For example, if the district's average percent covered by Medicaid is 37%, a salary split 63% TANF funds and 37% county funds could bill Medicaid for services. Services can be billed to other third- party payers including private insurance. Financial accountability should include the following:

- The patient should be informed of the availability of family planning fee options, including full price and sliding fee scale options.
- Income level should be obtained from every patient at each FP visit for compliance with federal funding requirements for reporting the percentage of population served that is less than 200% of FPL. Income can be self-declared.
- Proof of income can be requested as required by local district policy to be considered for sliding fee scale. However, services cannot be denied due to the inability to provide proof of income or the inability to pay.
- Patients should be informed of the need to bring in verification of income information at time of appointment if they would like to be considered for sliding fees.
- Fees may be waived and are encouraged to be waived when fee collection is a potential barrier to receiving services. Many districts automatically waive fees for some groups, including adolescents to ensure access to services.
- No person should be denied family planning services based on their inability to pay.
- Confidentiality must not be violated in the attempt to collect unpaid or outstanding fees. Full cost of services should be billed to third party coverage providers for patients covered by Medicaid, Medicare, or Insurance.

Program Income

- All monies collected as family planning fees (including from the third-party payers such as Medicaid or private insurance) must be recorded in compliance with the Department's program income policy.
- Program income generated from family planning services collected must be used to expand, improve, or offset the costs of the family planning service delivery system.
- Services cannot be denied because of inability to pay at the time of the visit.

Income Verification

Purpose: To determine eligibility for reduced cost or no cost services through income verification of patients seeking services in the FPP family planning clinics.

Verification Policies:
Defined within the income verification policies, the following areas must be addressed:

- Priority should be given to low- income families.
- A patient's inability to pay must not become a barrier to services.
- Income information should be obtained from every patient, documented, and updated at least annually.
- Income information may include but is not limited to:
  - Pay Stubs
  - W-2
  - Tax return
  - Military LES (leave or earning statement)
  - Letter from employer
  - Dividends or bonds
  - Net Rental Income
  - Food Stamps Documentation
  - Letter from Employer (undocumented patients)
  - WIC or SNAP approval letter showing family size and income
  - Unemployment Compensation
- Patients should be informed of the need to bring in verification of income information at time of appointment if they would like to be considered for sliding fee scale.
- Fees may be waived and are encouraged to be waived when fee collection is a potential barrier to receiving services (as outlined in financial accountability).
- Income reported through other programs offered may be used, rather than recertification of income in the family planning program.

It is the responsibility of the local health department and its designated personnel to develop, implement, and ensure compliance among all staff on the administration of income verification policies.

The local health department will ensure that staff are trained, and written policies are in place to address the above requirements associated with income verification. Refer to district policy for additional income verification guidance.

Chapter 8 Informed Consent

General Informed Consent

The Georgia Department of Public Health recommends a general consent for services be obtained for patients who request clinical services in public health settings. A general consent may be used to provide all services in FPP except for the insertion or removal of LARCs. The general consent should be resigned if there is a change in patient status, such as changing from minor to adult status.

Consent for LARC Contraceptive Method

Long-Acting Reversible Contraception (LARCs) includes intrauterine devices (IUD) and birth control implants. Both last for several years, provide ease of use for the patient, and are reversible. A Method Specific Consent Form must be obtained prior to inserting or removing LARCs. (Appendix C).

Chapter 9 Pharmacy

General Contraceptive Orders

The Women's Health Program and Office of Pharmacy monitors contraceptive utilization in alignment with district contraceptive orders and inventory without the need for district pharmacy allotments. Contraceptives made available through funding managed by the DPH Office of Women's Health will be made available by the districts to reproductive aged women who receive STD services and also desire contraception. The responsibilities that follow for the Districts, Office of Pharmacy, Finance, and Women's Health Program detail plans for contraceptive ordering and management in place of district pharmacy allotments for contraceptives.

Contraceptive Ordering including LARCs (District):

- Districts will base all orders for contraceptives available through the DPH Office of Pharmacy on contraceptive utilization by NDC. No more than two month's contraceptive supply should be maintained in any clinic location or district medication room/pharmacy.
- Family Planning patients of reproductive age must have access to **ALL** available methods of contraception through the formulary, including Long-Acting Reversible Contraceptives (LARCs), to comply with TANF requirements of comprehensive family planning services.
- Orders to the DPH Office of Pharmacy should be placed when available contraceptive inventory falls below two months expected use. These orders should be placed via Cardinal Order Express for those products available through Cardinal. For products outside of Cardinal, the pharmacy order form should be completed and sent to the Office of Pharmacy.
- Districts should indicate any increase or decrease in staff capacity to provide LARCS and any other changes in scheduling for LARCs in the quarterly online survey.

Billing and Program Income (District)

- Districts should bill private insurance at the allowable rate for LARCs for covered patients.
- Districts should follow Medicaid's Policy for 340B billing.
- Districts must make all contraceptive devices ordered through the DPH Office of Pharmacy available on a sliding fee schedule. The fee charged may exceed the purchase price.
- Contraceptives, including LARCs, ordered through the DPH Office of Pharmacy should be made available regardless of the patient's ability to pay (e.g., adolescents).
- All fees/income generated should be used in accordance with the TANF GIA Annex (#401) to support infrastructure for continued service provision.
- Family Planning funds must not be used to pay for sterilization.

Funding & Monitoring (DPH)

Pharmacy will:

- Determine the amount of funds to be placed on each purchase order.
- Process receipts in PeopleSoft.
- Provide a monthly pharmaceutical spending update report to the Women's Health Program and assigned budget staff. The report will be used to track spending availability and invoice receipt information.
- Process all orders requested by districts within (3) business days (contingent upon available funding and inventory).
- Meet monthly with Women's Health Program staff to review LARC and other contraceptive purchasing and obtain pharmaceutical utilization by NDC from the program to assure alignment with district orders.

Finance:

- Process all vendor payments for pharmaceuticals in accordance with contract payment terms.
- Review pharmacy spending update report with Women's Health Program staff monthly.

Women's Health Program:

- Determine the pharmacy annual budget amount.
- Initiate purchase order process for all pharmaceuticals by July 1st. Funding availability for contraceptives will be based on Women's Health Program funding for the upcoming year.
- Meet monthly with Pharmacy staff to review LARC and other contraceptive utilization by NDC to assure alignment with district orders and maintain two-month local supply.
- Review pharmacy spending update report with Finance staff monthly.
- Notify the District Health Directors, Women's Health Coordinators and Office of Pharmacy of any variances in spending or funding shortfalls.

- Communicate any anticipated or upcoming changes in contraceptives supply provided through the Office of Pharmacy to District Health Directors, Women's Health Coordinators, and district pharmacy contacts.

Chapter 10 Clinical Guidelines

The purpose for clinical guidelines is to describe the requirements and recommendations for FPP providers in the delivery of family planning services to patients.

Nursing Protocols

All nurses functioning under nurse protocol must follow protocols signed by their district health director/delegating physician. The Office of Nursing publishes protocols and standard guidelines for public health nurses. The protocols may be accessed on PHIL 2.0 in the in the Office of Nursing Section at https://gets.sharepoint.com/sites/PHIL#/Home. In accordance with Nurse Protocol Guidelines, it is expected that districts will adopt the protocols without modification. Modifications must be reviewed by the Office of Nursing and approved by the state office.

Patient Health Record (Medical Record)

Family Planning providers must ensure that a patient health record (medical record) is established for every patient who obtains clinical services.

Initial and Annual Exams

Medical History and Risk Assessment

At the initial visit, a ***focused*** medical history applicable to the dispensing of contraceptives should be obtained. The medical history should be reviewed and updated at each subsequent visit.

The comprehensive medical history should at least address the following:

- Current health status, including acute and chronic medical conditions.
- Significant past illnesses, including hospitalizations.
- Previous surgery and biopsies with dates and results (final diagnosis/pathology) when pertinent and if possible.
- Blood transfusions and other exposure to blood products.
- Current medications (prescription, over the counter (OTC), complementary/alternative).
- Allergies, sensitivities or reactions to medicines and other substances.
- Use of tobacco/vaping/alcohol/illicit drugs (including type, duration, frequency, route).
- Immunization history.
- Review of systems with pertinent positives and negatives related to the use of contraceptives documented in medical record.
- Assessment for intimate partner violence and sexual violence (including safety assessment, if indicated).
- Pertinent mental health history (e.g., depression, anxiety).

- Pertinent family history.
- General well-being (e.g., nutrition, exercise).

Reproductive health history in female patients should include the following:

- A reproductive life plan that assesses pregnancy intention and includes whether the patient wants to have any or more children and, if so, the desired timing and spacing of those children.
- Menstrual history including last menstrual period, menstrual frequency, length, and amount of bleeding, and other patterns of uterine/vaginal bleeding.
- Sexual behavior history, including family planning practices (contraceptive experience – past and current), contraceptive preferences, number of partners, gender of sexual partners, last sexual encounter, and sexual abuse.
- Partner history including injectable drug use, STI and HIV history and risk factors.
- Obstetrical history including dates, complications, outcomes, when last pregnancy ended, and if currently breastfeeding.
- Gynecological and urologic conditions.
- STIs and HIV/HBV history, risks, and exposure.
- Cervical cancer screening history (date and results of last Pap test or other cervical cancer screening test, including abnormal results and treatment).

Physical Assessment

A physical examination is not essential prior to the provision of most contraceptive methods and should not be a barrier to the patient receiving a method of contraception. Most women will need no or few examinations or laboratory tests before starting a method of contraception.

See Nurse Protocol's for Women's Health and *CDC's Providing Quality Family Planning Services* for examination components that are essential for safe and effective use of specific contraceptive methods and those recommended for preventive care and health screening.

Access the GA Public Health Nurse Protocol's for Women's Health on PHIL 2.0 at http://dphphil.org.

Access the CDC's *Providing Quality Family Planning Services* at: https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf

Laboratory Services

Women's Health Nurse Protocols provide guidelines for labs indicated for contraceptive management and women's health care.

The following tests or procedures must be provided on-site:

- Cervical cancer screening
- Sexually transmitted infection testing
- Pregnancy test
- HIV Testing

Depending on the setting, some tests may require referral. Offering preventive care and health screening is valuable for overall health; however, laboratory tests are not necessary for safe provision of contraception, unless required by protocol. Clinicians should follow BCCP guidelines for screening in special populations and for follow-up of abnormal screening.

Districts must have written plans to address laboratory and other diagnostic test orders, results, and follow-up to include:

- Tracking test results and documentation in patients' records.
- Mechanism to notify patients of results in a manner to ensure confidentiality and prompt, appropriate follow-up.
- Procedures for follow-up of referrals that are made as a result of abnormal physical examination findings, laboratory test findings or clinical assessment (e.g., pelvic mass, suspicious skin lesion).

Districts must assure compliance with state and local notifiable disease reporting requirements, as well as follow-up requirements of the Breast and Cervical Cancer Program. Refer to the GA Breast and Cervical Cancer Program Manual [current edition] for referral of abnormal clinical breast exam, mammography policy and procedure, and cervical cancer screening and referral.

A guide for specimen requirements at the Georgia Public Health Laboratory (GPHL) can be found in the Laboratory Service Manual at http://dph.georgia.gov/lab.

Revisits

Revisits should be individualized based upon the patient's contraceptive management needs, exam and lab findings, education and counseling needs, or as determined by the clinician.

STI and HIV Prevention

The purpose is to provide screening, treatment, counseling, and referral for sexually transmitted infections (STI) and human immunodeficiency virus (HIV) to family planning patients seeking services in FPP clinics. STI and HIV referrals should be done only when the patient cannot be managed in the Family Planning clinic.

All patients must receive accurate and thorough patient-centered counseling about STIs and HIV to include:

- Discussion about personal risks.
- Consequences of untreated infections.
- Risk reduction and infection prevention information to address sexual abstinence, mutual. monogamy with an uninfected partner, and/or condom use, as appropriate for the patient.
- Referral services.
- Information about their risk behaviors, symptoms, and their partners.

HIV Testing

FPP Providers are required to offer on-site HIV testing. ***Staff who provide HIV testing and counseling are required to complete DPH HIV Program required training elements for HIV testing and counseling.***

HIV testing is recommended at least one time for patients in health-care settings. The patient should be notified that testing will be performed unless the patient declines or refuses (opt-out). Patients should not be tested without their knowledge. Subsequent tests are performed on the basis of clinical judgment and patient risk. Patients at high risk for HIV infection should be screened for HIV at least annually. Patients likely to be at high risk include:

- Injection drug users and their sex partners.
- Persons who exchange sex for money or drugs.
- Sex partners of HIV-infected persons.
- Men who have sex with men (MSM) or heterosexual persons who themselves (or whose sex partners) have had more than one sex partner since their most recent HIV test.
- Persons who have been diagnosed with or sought treatment for another Sexually Transmitted Infection (STI).

CDC Recommendations for HIV screening can be found at:
http://www.cdc.gov/hiv/testing/clinical/

Referral and Follow-Up of Health Care Needs

Patients should be assisted to meet all identified health care needs, either directly or by referral. Districts must have written policies and procedures for following up on referrals that are made as a result of abnormal physical examination or laboratory test findings.

For services determined to be necessary but are not provided by the clinic, patients must be referred to other resources for care. Whenever possible, patients should be given a choice of referral resources from which to select. A referral resource list of local health providers, hospitals, community, and health and social service agencies should be maintained and available to the patient. The resource information should be reviewed and revised as needed, at least annually.

When a patient is referred to another resource because of a serious abnormal finding or for emergency clinical care, the provider should arrange for the provision of pertinent patient information to the referral resource and obtain required patient consent (with appropriate safeguards to ensure confidentiality – i.e., adhering to HIPAA regulations).

The referring provider should:

- Advise the patient about his/her responsibility in complying with the referral.
- Follow up to determine if the referral was completed.
- Document the outcome of the referral (including patients refusing referral and/or follow-up).

Patient Education and Counseling

The purpose of patient education and counseling is to assist patients in making and sustaining informed decisions regarding their reproductive health. Education is a key component in the counselling process as it helps patients make informed decisions. The evidence-based practices for patient education and counseling outlined in this section are based on recommendations by the CDC's *Providing Quality Family Planning Services* which can be accessed at http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

General Guidance Regarding Education and Counseling

- Districts should have a process in place to ensure patient education materials are evidence-based and up to date.
- Education must be documented in the patient's record to indicate that the patient verbalized understanding of education and counseling (Use the Education Check Sheet in Appendix D as a tool).
- Education and counseling should be:
    - Provided based on age, language, cultural background, literacy, emotional state, and readiness for behavior change.
    - Unbiased.
    - Delivered through verbal, written and/or by audio-visual methods of communication.

The use of an education key is recommended to define each educational component, as it may decrease the need for repetitive charting and standardize education information. The example of an education key is included in the appendix as a reference. (Appendix D).

Education and Counseling: Initial Visit

Education and counseling during the initial visit should be based on the patient's history, current status, and plans for contraception and/or pregnancy. For education and counselling on specific conditions and contraceptive methods, refer to the current Women's Health Nurse Protocol. All education and counseling requirements are aligned with 340B and TANF data reporting components:

- STD Prevention/Safe Sex Education – 340B Data Reporting (Code 013).
- Reproductive Health Counseling – TANF Data Reporting (Code 014).

The following educational elements should be included at the initial family planning visit:

- General benefits of family planning services and contraception for family and individual health.
- Sequence, purpose and importance of tests and procedures during the clinic visit.
- Information on all contraceptive methods with emphasis on safest and most effective methods.
- Information on long-acting reversible contraception.
- Risk reduction strategies for sexually transmitted infections and human immunodeficiency virus (HIV).

- Women should be told about the benefits and limitations of the self-breast exam (SBE).

Additional education should be provided based on patient needs and may include the following:

- Basic female reproductive anatomy and physiology
- Preconception counseling
- Nutrition
- Exercise
- Smoking cessation
- Substance use and abuse
- Domestic violence
- Abuse
- Reproductive coercion

Education and Counseling Required for Return Patients

Return family planning visit education should include the following:

- Review of current method of contraception, plans for contraception and/or review of contraceptive options**.**
- STD, HIV risks and prevention.
- Other education and counseling as appropriate based on patient needs.

Adolescents: Additional Education and Counseling: First Time Visit

In addition to the educational information required for all patients, adolescent patients require skilled counseling and age-appropriate information. Female adolescents **must** be provided individualized family planning counseling and clinical services that meet their specific needs. Counseling should prepare adolescents to use a variety of methods effectively, as contraceptive needs may change frequently.

The following educational components must be provided and documented for each adolescent who receives family planning services:

- Abstinence as an effective way to prevent pregnancy and STDs.
- Providing all methods of contraception as an option, whether or not adolescent has been pregnant or given birth.
- Discussion about partner, date, and family violence, as well as available resources and/or assistance.
- Promotion of communication between the adolescent and his or her parent(s) or guardian(s) about sexual and reproductive health.

See **Appendix E** for GA Laws Related to Right of a Minor to Obtain Medical Care without the Consent or Knowledge of Parents.

Reproductive Life Plan

A reproductive life plan is a set of questions designed to assess an individual's intent to have or not have a baby. A reproductive life plan is completed during encounters that include an assessment of:

- Contraceptive methods and supplies.
- How often the patient's primary contraceptive is used.
- Pregnancy intendedness.

Preconception Counseling

The goal of preconception counseling is to improve the health of women, men, and couples before conception of a first or subsequent pregnancy. Counseling on preconception health is different for every patient, depending on their unique needs, and should align with the patient's reproductive life plan. Steps to achieve a healthy pregnancy are outlined on CDC's website: Preconception Health and Health Care, Planning for Pregnancy.

http://www.cdc.gov/preconception/planning.html

Pregnancy Testing and Counseling

Pregnancy testing and counseling is a required service and is an important entry point for providing education and counseling about family planning.

For additional information, refer to the Pregnancy and Counseling section in *Providing Quality Family Planning Services, Recommendations of CDC and the U.S. Office of Population Affairs* http://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf.

The following are guidelines for educating patients on pregnancy test results.

Positive Test Results

When the test results are positive, pregnancy counseling provides the following:

- Provide test results.
- If the patient plans to continue the pregnancy, provide referral information for prenatal providers, and emphasize the importance of seeking care early in the pregnancy.
- Provide information about good health practices during pregnancy including:
    - Taking a daily prenatal vitamin that includes folic acid.
    - Avoidance of smoking, drugs, alcohol.
    - STI screening and prevention.
    - Avoidance of exposure to x-rays.
    - Avoidance of eating fish that might have high levels of mercury.
    - Review of signs/symptoms of ectopic pregnancy.
    - Informing patient that some medications might be contraindicated in pregnancy and any current medications taken during pregnancy need to be reviewed by a prenatal care provider.
- Complete assessment or referral to determine Medicaid eligibility.

- Referral to appropriate providers of follow-up care should be made at the request of the patient, as needed.
- Assess the patient's social support and refer her to appropriate counseling or other supportive services, as needed.
- Referral for WIC.

All referrals must be documented in the patient's medical record.

Negative Pregnancy Test Results

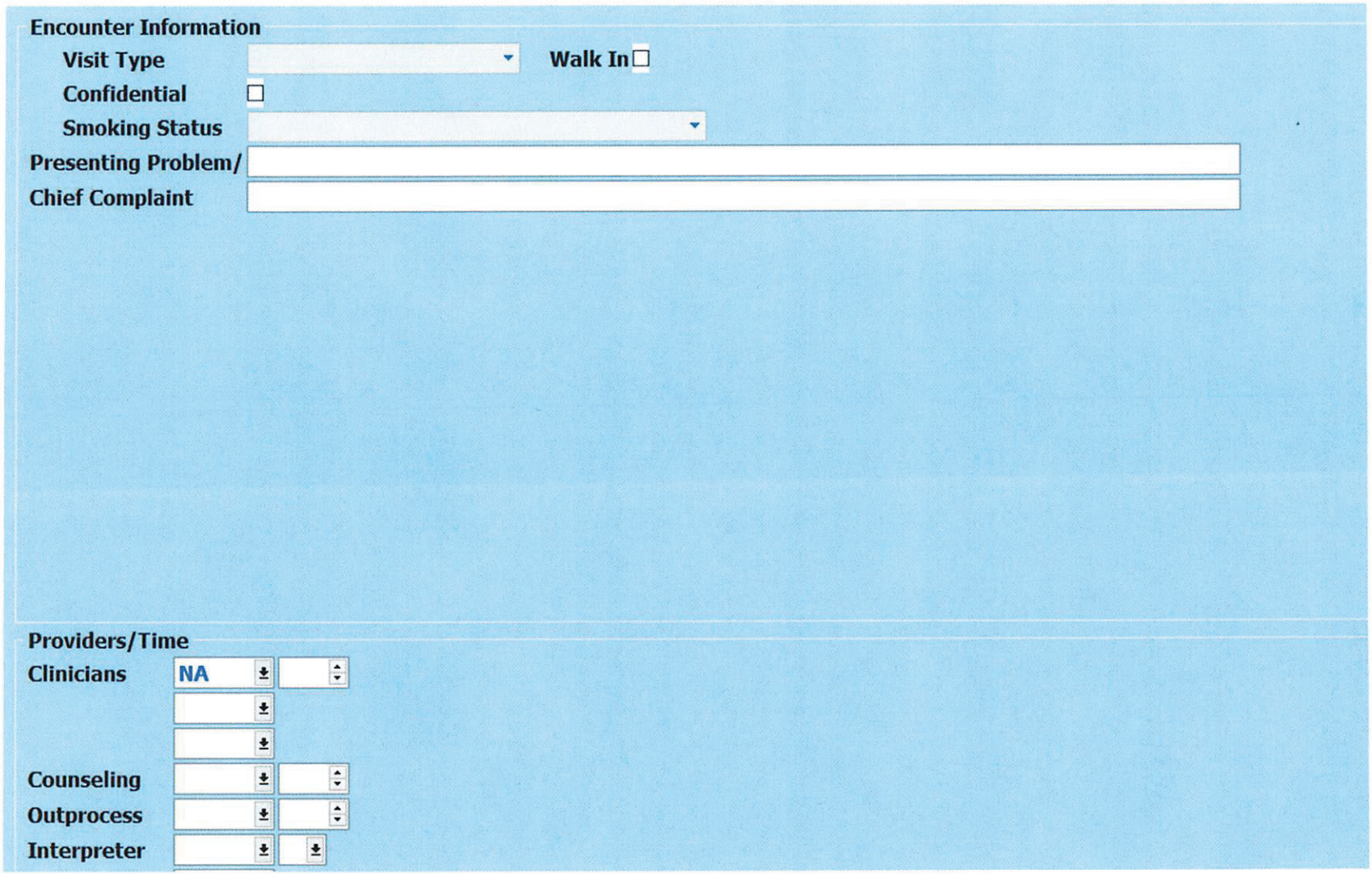
For women who are not pregnant and who do not want to become pregnant:

- Patient should be offered contraceptive services.
- Counseling should explore the following:
  - Why the patient thought she was pregnant and sought pregnancy testing services.
  - Whether the patient has difficulties using her current method of contraception.
- Discuss the value of making a reproductive life plan.
- Patients who have decided to delay pregnancy should be given information about contraception and the availability of contraceptive and infertility services as appropriate.
- Offer preconception health counseling to women who are not pregnant and want to become pregnant.
- Provide information regarding STI treatment and prevention.

Appendix A

FP Encounter Screen Shots

FP Encounter Info



Program Details – Page 1

Family Planning

Contraceptive Methods | Supplies | Clinical Survey

Primary Before	Primary After	Secondary Before	Secondary After
Abstinence	Abstinence	Abstinence	Abstinence
Diaphragm	Diaphragm	Diaphragm	Diaphragm
ECP	ECP	ECP	ECP
Female Condom	Female Condom	Female Condom	Female Condom
Fertility Awareness	Fertility Awareness	Fertility Awareness	Fertility Awareness
Implant	Implant	Implant	Implant
IUD - Hormonal	IUD - Hormonal	IUD - Hormonal	IUD - Hormonal
IUD - Non Hormonal	IUD - Non Hormonal	IUD - Non Hormonal	IUD - Non Hormonal
Male Condoms	Male Condoms	Male Condoms	Male Condoms
None	None	None	None
One Month Inj	One Month Inj	One Month Inj	One Month Inj
Orals	Orals	Orals	Orals
Other	Other	Other	Other
Partner's Method	Partner's Method	Partner's Method	Partner's Method
Patch	Patch	Patch	Patch
Spermicide	Spermicide	Spermicide	Spermicide
Sterilization(Female)	Sterilization(Female)	Sterilization(Female)	Sterilization(Female)
Three Month Inj	Three Month Inj	Three Month Inj	Three Month Inj
Unknown	Unknown	Unknown	Unknown
Vaginal Ring	Vaginal Ring	Vaginal Ring	Vaginal Ring
Vaginal Method - Non-hormonal	Vaginal Method - Non-hormonal	Vaginal Method - Non-hormonal	Vaginal Method - Non-hormonal
Vasectomy	Vasectomy	Vasectomy	Vasectomy
	Quantity		Quantity

Program Details – Page 2

Family Planning

Contraceptive Methods | Supplies | Clinical Survey

Intendedness	○ Within 1 Yr. ○ 1-2 Yrs. ○ 2-5 Yrs. ○ 5 Yrs or More ○ Undesired ○ Don't Know
CBE	○ Yes ○ No ○ N/A
Last Pregnancy	
Reproductive Life Plan	○ Yes ○ No
How did you hear about us?	○ Media-Advertisement ○ Referral from medical provider ○ Family or friends ○ Health department referral ○ Other

Education – Data Reporting Components

Code	Description	Select
O2	ABSTINENCE SKILLS TRAINING	☐
O5	AOD USE REFERRAL	☐
O7	CONTRACEPTIVE COUNSELING ONLY	☐
O12	HIV COUNSELING	☐
O10	MAMMOGRAM REFERRAL	☐
O11	MEDICAID / PEACHCARE REFERRAL	☐
O3	NFP INSTRUCTION	☐
XX	NO REQUIRED PROCEDURES PROVIDED	☐
O6	OTHER REFERRAL(S)	☐
O14	REPRODUCTIVE HEALTH COUNSELING	☐
O13	STD PREVENTION/SAFE SEX EDUCATION	☐

Appendix B

SAMPLE Family Planning Program Record Review Tool

M=met
NM=not met
NA=not applicable

District/Clinic:

Clinician Name & Credentials:

	Record 1	Record 2	Record 3	Record 4	Record 5	Record 6	Record 7	Record 8	Record 9	Record 10
Date of Review										
Client ID #										
Client age										
Gender										
Visit Type										
Annual										
Initial										
Brief Medical										
Pregnancy Diagnosis and Counseling										
Consents										
General Consent for Services Signed										
Method Specific Consent Signed (if appropriate)										
Clinical & Social Assessment										
Allergies										
Medical (including chronic health conditions)										
Menstrual										
Gynecologic										
Obstetrical (full term, premature, miscarriage, pregnancy history including dates, whether currently breast feeding)										
Contraceptive History/Preferences										
Sexual Health (partners, practices, prevention of STDs, past STDs)										
Partner violence/Mental Health/Substance abuse										

SAMPLE Family Planning Program Record Review Tool

District/Clinic:

Clinician Name & Credentials:

M=met
NM=not met
NA=not applicable

Smoking/Illicit drugs/Alcohol/Meds										
Date last intercourse/Method used										

	Record 1	Record 2	Record 3	Record 4	Record 5	Record 6	Record 7	Record 8	Record 9	Record 10
Pregnancy Intentions/Reproductive Plan										
Physical Assessment										
BMI										
Blood Pressure (if appropriate)										
Exam appropriate according to WH Protocols (needs, health, age)										
No unnecessary procedures										
Lab Tests										
Appropriate according to WH Protocols (needs, health age)										
No unnecessary tests										
Assessment										
Appropriate & based on history, exam & lab findings										
Plan										
Follow-up of previous problems & referrals										
Appropriate tests ordered/done										
Pharmacologic & nonpharmacologic plan appropriate										
Education & counseling appropriate and documented (preconception health, smoking, adolescent counseling, BMI, other)										

SAMPLE Family Planning Program Record Review Tool

M=met
NM=not met
NA=not applicable

District/Clinic:

Clinician Name & Credentials:

Referrals (primary care, Ob/Gyn, other specialist, other agency or program) as indicated										
Appropriate interval for next appointment and follow-up										

Comments:

Record 1	Record 6
Record 2	Record 7
Record 3	Record 8
Record 4	Record 9
Record 5	Record 10

SAMPLE Family Planning Program Record Review Tool

M=met
NM=not met
NA=not applicable

District/Clinic:

Clinician Name & Credentials:

Dates & Signatures for Record Reviews

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Date: _____ Reviewer: _____ Date: _____ Delegating MD: _____	Date: _____ Reviewer: _____ Date: _____ Delegating MD: _____	Date: _____ Reviewer: _____ Date: _____ Delegating MD: _____	Date: _____ Reviewer: _____ Date: _____ Delegating MD: _____

SAMPLE Family Planning Program Record Review Improvement Plan

Note: This form is to be completed only if there are unmet criteria

District & County Health Department:

Date:

FP Provider Name & Credentials:

Criteria not met: (include date of review and client ID #)

_____
_____
_____
_____
_____
_____
_____

Recommendation(s)/plan for improvement: (may include workshops, teleconferences, audio conferences, directed readings or other independent study and additional record reviews)

_____
_____
_____
_____
_____
_____
_____
_____

Signature of person providing feedback: _____

Clinician signature/date: _____

Comments:

_____
_____
_____

Appendix C

Georgia Department of Public Health

Patient Name_____ Date of Birth_____

Health Center Name	**VOLUNTARY CONSENT FOR REMOVAL OF CONTRACEPTIVE IMPLANT**

REMOVAL PROCEDURE:
I have been advised that the following is the procedure used for removal:

After cleansing the area on the arm where the contraceptive implant is located, a local anesthetic (Lidocaine) will be injected into the site. A small incision approximately 2-3 mm will be made with a scalpel. The contraceptive implant will then be separated from the surrounding tissue and removed. In some cases, removal of the implant may be difficult. A second incision may be necessary to remove the capsule. If remaining capsule need to be removed, you will need to return in 4 to 6 weeks (after the site has healed). Steri-strips or bandages are placed across the incision after the removal. The length of time required for the removal process varies from person to person; 30 minutes or more may be required. If the removal is difficult or not possible, you may be referred to another provider to have the implant removed.

WARNING SIGNS OF POSSIBLE PROBLEMS:
I understand that I should return to the clinic, hospital emergency room or doctor's office at once, if I start having any of the following:

- Redness, pus or bleeding at the removal site
- Prolonged (48 hrs. after removal) swelling or bruising at or near the removal site
- Fever
- Reaction to the anesthetic

I understand that if I have any questions or concerns about post-removal care, I should contact the health department or my local primary care doctor. I also understand that rapidly after a contraceptive implant has been removed, most women return to their pre-insertion fertility rate; therefore, I should use another method of birth control right away if I don't want to get pregnant. I know that I may get another method of my choice from this clinic.

I have been given the chance to ask questions about care following the removal and have had all my questions answered to my satisfaction. I have been advised and understand the risks involved in this removal procedure. I have considered these factors and voluntarily choose to have the contraceptive implant removed. It is my responsibility to request or seek another method of birth control if I so desire. I have read this form or have had it read to me, and understand the information on this form. I have received written information on other methods of birth control. I accept the risks of having the contraceptive implant removed.

Patient's Signature _____Print Name_____Date _____

Counselor's Signature_____Print Name_____Date_____

Clinician Performing Removal Signature_____Print Name_____Date_____

<u>After the contraceptive implant was removed</u>, I was shown _____ intact capsule that was removed from my arm.

Patient's Signature_____ Print Name_____Date_____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Nombre del paciente _____ Fecha de nacimiento _____

Nombre del Centro de Salud	**CONSENTIMIENTO VOLUNTARIO PARA RETIRAR EL IMPLANTE ANTICONCEPTIVO**

PROCEDIMIENTO PARA RETIRARLO:

Me informaron que el procedimiento siguiente es el que se utiliza para retirarlo:

Luego de limpiar el área del brazo en la que se encuentra el implante anticonceptivo, se procederá a inyectar un anestésico local (lidocaína) en el sitio. Harán una incisión pequeña de aproximadamente 2 a 3 mm con un bisturí. Separarán el implante del tejido que lo rodea y lo retirarán. En algunos casos, puede ser difícil retirar el implante. Se puede necesitar una segunda incisión para retirar la cápsula. Si es necesario retirar el resto de la cápsula, deberé que volver entre dos a cuatro semanas (después de cicatrizada la herida). Después de retirar el implante, me colocarán vendajes o suturas adhesivas (Steri-strips) sobre la incisión. La duración del procedimiento de retiro del implante varía de persona a persona; puede tardar 30 minutos o más. Si el procedimiento para retirarlo se dificulta o se hace imposible, me pueden referir a otro profesional para que lo retiren.

SIGNOS DE ADVERTENCIA DE POSIBLES PROBLEMAS:
Entiendo que debo regresar de inmediato a la clínica, a la sala de emergencias del hospital o al consultorio del médico si comienzo a presentar alguna de las situaciones siguientes:

- Enrojecimiento, pus o sangrado en el sitio de retiro del implante
- Inflamación prolongada o hematoma (48 horas después) en o cerca del sitio de retiro
- Fiebre
- Reacción al anestésico

Entiendo que si tengo preguntas o alguna preocupación sobre el cuidado posterior al retiro, debo contactar al departamento de salud o a mi profesional de atención primaria local. También entiendo que las mujeres recuperan su índice de fertilidad previo al implante muy poco tiempo después del retiro, por lo que debo usar otro método anticonceptivo si no quiero quedar embarazada. Sé que en esta clínica me pueden dar otro método de mi elección.

Tuve la oportunidad de hacer preguntas sobre el cuidado que debo tener después del retiro del IUD y me las respondieron todas de manera satisfactoria. Me notificaron y entiendo los riesgos que implica este procedimiento de retiro. He tomado en cuenta estos factores y elijo de manera voluntaria someterme al retiro del IUD. Asumo la responsabilidad de buscar o solicitar otro método anticonceptivo, si así lo deseo. He leído o me han leído este formulario y comprendo la información que contiene. He recibido información escrita sobre otros métodos anticonceptivos. Acepto los riesgos de someterme al retiro del implante anticonceptivo.

Firma de la paciente _____ Nombre en letra imprenta _____ Fecha _____

Firma del orientador _____ Nombre en letra imprenta _____ Fecha _____

Firma del médico que realizó el retiro _____ Nombre en letra imprenta _____ Fecha _____

<u>Luego de haber retirado el implante anticonceptivo</u>, me mostraron _____ la cápsula intacta que me fue retirada del brazo.

Firma de la paciente _____ Nombre en letra imprenta _____ Fecha _____

Georgia Department of Public Health

Patient Name_____ Date of Birth_____

Health Center Name	**VOLUNTARY CONSENT FOR REMOVAL OF INTRAUTERINE DEVICE (IUD)**

REMOVAL PROCEDURE:
I have been advised that the following is the procedure used for removal:

After placing a speculum, the provider will grasp the IUD strings with an instrument and provide gentle traction to remove it. In some cases, removal may be difficult, or discomfort may occur. Removal may be associated with some pain, bleeding, or vasovagal reactions (for example, fainting or a seizure in an epileptic patient). If removal is complex or the IUD is unable to be completely removed, I may be referred to another provider to have it removed. It is my responsibility to notify my provider if I think I may be pregnant. Removal of the IUD with pregnancy may cause a miscarriage.

WARNING SIGNS OF POSSIBLE PROBLEMS:
I understand that I should return to the clinic, hospital emergency room or doctor's office at once, if I start having any of the following:

- Foul vaginal discharge
- Pelvic pain
- Fever

I understand that if I have any questions or concerns about post-removal care, I should contact the health department or my local primary care doctor. I also understand that rapidly after an IUD has been removed, most women return to their pre-insertion fertility rate; therefore, I should use another method of birth control right away if I don't want to get pregnant. I know that I may get another method of my choice from this clinic.

I have been given the chance to ask questions about care following the removal and have had all my questions answered to my satisfaction. I have been advised and understand the risks involved in this removal procedure. I have considered these factors and voluntarily choose to have the IUD removed. It is my responsibility to request or seek another method of birth control if I so desire. I have read this form or have had it read to me and understand the information on this form. I have received written information on other methods of birth control. I accept the risks of having the IUD removed.

Patient's Signature _____Print Name_____Date_____

Counselor's Signature_____Print Name_____Date_____

Clinician Performing Removal Signature_____Print Name_____Date_____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Nombre del paciente _____ Fecha de nacimiento _____

Nombre del Centro de Salud	**CONSENTIMIENTO VOLUNTARIO PARA RETIRAR EL DISPOSITIVO INTRAUTERINO (IUD)**

PROCEDIMIENTO PARA RETIRARLO:
Me informaron que el procedimiento siguiente es el que se utiliza para retirarlo:

Después de colocar un espéculo, el médico sujetará las cuerdas del IUD con un instrumento y las halará suavemente para retirarlo. En algunos casos, se puede dificultar el retiro del implante o sentir alguna molestia. El retiro del implante puede asociarse a un dolor, sangrado o reacciones vasovagales (como un desmayo o convulsiones, si la paciente es epiléptica). Si el procedimiento de retiro del implante es complejo o no se lograr retirar el IUD por completo, me pueden referir a otro departamento para que lo retiren. Si sospecho estar embarazada, tengo la responsabilidad de notificárselo a mi médico. El retiro del IUD durante el embarazo puede provocar un aborto natural.

SIGNOS DE ADVERTENCIA DE POSIBLES PROBLEMAS:
Entiendo que debo regresar de inmediato a la clínica, a la sala de emergencias del hospital o al consultorio del médico si comienzo a presentar alguna de las situaciones siguientes:

- Flujo vaginal con mal olor
- Dolor pélvico
- Fiebre

Entiendo que si tengo preguntas o alguna preocupación sobre el cuidado posterior al retiro, debo contactar al departamento de salud o a mi médico de atención primaria local. También entiendo que las mujeres recuperan su índice de fertilidad previo al implante muy poco tiempo después de que se lo hayan retirado, por lo que debo usar otro método anticonceptivo, si no quiero quedar embarazada. Sé que en esta clínica me pueden dar otro método de mi elección.

Tuve la oportunidad de hacer preguntas sobre el cuidado que debo tener después del retiro del IUD y me las respondieron todas de manera satisfactoria. Me notificaron y entiendo los riesgos que implica este procedimiento de retiro. He tomado en cuenta esos factores y elijo de manera voluntaria someterme al retiro del IUD. Asumo la responsabilidad de buscar o solicitar otro método anticonceptivo, si así lo deseo. He leído o me han leído este formulario y entiendo la información que contiene. He recibido información escrita sobre otros métodos anticonceptivos. Acepto los riesgos de someterme al retiro del IUD.

Firma de la paciente _____ Nombre en letra imprenta _____ Fecha _____

Firma del orientador _____ Nombre en letra imprenta _____ Fecha _____

Firma del médico que realizó el retiro _____ Nombre en letra imprenta _____ Fecha _____

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Patient Name_____ Date of Birth_____

Health Center Name	**VOLUNTARY CONSENT FOR USE OF THE NEXPLANON SUBDERMAL CONTRACEPTIVE IMPLANT**

I have voluntarily chosen the Nexplanon subdermal contraceptive implant as my method of birth control. I understand that Nexplanon is a soft, flexible plastic rod, the size of a matchstick that is placed under the skin of the upper arm. Nexplanon constantly releases a progestin hormone called etonogestrel. Nexplanon also contains a small amount of a substance called barium sulfate so it can be seen on x-ray. No method can prevent pregnancy 100% of the time. Nexplanon is a very effective, reversible (not permanent) long-term method of birth control that can be as effective as 99.9% in preventing pregnancy. If I decide to stop using Nexplanon, I know that I must return to a clinic or other health care professional to have it removed.

BENEFITS: Nexplanon is highly effective and can stay in place for up to 3 years before it needs to be replaced. Studies show that the implant can be effective for longer than the time for which it is approved. I should talk to my provider about this if I am interested in using the method for longer. Most women are not able to see the Nexplanon after insertion. There may be less cramping with periods with the implant.

The hormone in Nexplanon passes into breast milk. Women who are breastfeeding and want to use Nexplanon should discuss this with their health care provider.

SIDE EFFECTS AND RISKS: I know that while using Nexplanon, I may have the following problems:

- The most common side effect of Nexplanon is a change in normal menstrual pattern. Menstrual changes, which are common, may include bleeding or spotting between periods, irregular periods, longer or shorter periods, heavy or light periods or periods may completely stop.
- Besides changes in menstrual patterns other possible side effects include the following: mood swings, depression, thrombosis, weight gain, headaches, acne or skin problems and pain or rarely, infection, at the insertion site.
- Pregnancy is extremely rare with a Nexplanon; however, if pregnancy does happen while using Nexplanon, there is a slightly greater chance that the pregnancy will be ectopic or outside the womb. Ectopic pregnancy can cause serious internal bleeding, inability to get pregnant and death.
- Cysts on the ovary that usually go away without treatment but sometimes need surgery to remove them.
- Complications with insertion or removal of Nexplanon including irritation, pain, swelling, bruising, infection, numbness, migration to vasculature or scarring at insertion site. Also, broken or bent implants may occur due to external forces (e.g., manipulation of the implant or contact sports) while in the patient's arm. The release rate of etonogestrel may be slightly increased in the event the implant is broken or bent. Very rarely an implant may come out by itself, break during removal or require surgery for removal.
- Women with breast cancer or a history of breast cancer should not use Nexplanon.

I understand that I should return to the clinic, hospital emergency room or doctor's office as soon as possible if I have any of the following:

- If think I might be pregnant, especially if I have any of the following problems since they could be caused by an ectopic pregnancy (pregnancy outside the uterus): abnormal vaginal bleeding, lower stomach pain or tenderness and fainting
- Heavy menstrual bleeding
- Symptoms of severe allergic reaction such as swollen tongue or throat, hives or trouble swallowing
- Severe headaches, or worsening of headaches

- Yellowing of the skin or white of the eyes, especially with fever, tiredness, loss of appetite, dark colored urine or light colored bowel movements
- Severe abdominal pain
- Lump in my breast
- Severe depression

ALTERNATIVES: The other methods of birth control have been explained to me and I have been given written information on them.

INSTRUCTIONS: I have been given written information about the Nexplanon including the Nexplanon FDA-Approved Patient Labeling. I have been advised and I understand that Nexplanon has been approved for three years of use; studies indicate that it may be effective for longer and if I am interested in using this longer, I should discuss this with my provider. I can have the Nexplanon removed sooner if I want. I have been taught that I can check for the Nexplanon by feeling my upper arm. I understand that I should contact my health care provider immediately if at any time I am unable to feel the implant. Migration of the implant has been reported.

I have been advised to tell my healthcare provider about all the medicines I take both prescription and non-prescription since certain medicines may make Nexplanon less effective and Nexplanon can change how well certain medicines work. I have been advised that I should tell my healthcare providers that I have Nexplanon in my arm.

I have also been told that the implant does not protect me from HIV/AIDS and/or other sexually transmitted diseases. For better protection from these diseases, I should also use condoms.

DECISION TO STOP USING NEXPLANON: Using this method is completely voluntary. I have been told that I have the right to stop using the implant at any time. To have the Nexplanon removed, I must return to the clinic or go to another qualified medical provider. If I have trouble finding a qualified medical provider, I can call 1-877-467-5266 for help. Removal is a minor surgical procedure, but sometimes removal can be difficult, or in rare cases, impossible. Difficult removals may cause pain and scarring and may result in injury to nerves and blood vessels. Special procedures, including imaging methods to locate the implant and surgery in the hospital, may be required. Once the implant is removed, I am no longer protected against pregnancy and I should start using another method of birth control right away if I do not want to become pregnant. If the implant is not removed, its effects may continue.

QUESTIONS: I have been given the chance to ask questions about Nexplanon and about this consent form, and have had all my questions answered to my satisfaction.

I have read this form or have had it read to me, and I understand the information on this form. I accept the risks of using the contraceptive implant, Nexplanon.

Patient's Signature	Print Name	Date

Counselor's Signature	Print Name	Date

A client is required to sign this form at the initiation/re-initiation of this contraceptive method or if there is a major change in the health history.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Nombre del paciente_____Fecha de nacimiento_____

Nombre del Centro de Salud	**CONSENTIMIENTO VOLUNTARIO PARA USO DEL IMPLANTE ANTICONCEPTIVO SUBDÉRMICO NEXPLANON**

He elegido voluntariamente el implante anticonceptivo subdérmico Nexplanon como método de control de natalidad. Entiendo que Nexplanon es una varilla de plástico suave y flexible del tamaño de un fósforo, que se coloca debajo de la piel en la parte superior del brazo y libera, de manera constante, una hormona progestina llamada etonogestrel. También contiene una pequeña cantidad de una sustancia llamada sulfato de bario, para que pueda verse en una radiografía. Si bien ningún método puede prevenir el embarazo el 100 % de las veces, Nexplanon es un método anticonceptivo muy eficaz, reversible (no permanente) y a largo plazo, que puede tener un 99.9 % de eficacia en la prevención de embarazos. Si decido dejar de usar Nexplanon, sé que debo acudir a una clínica o un profesional de la salud para que lo retire.

BENEFICIOS: Nexplanon es muy efectivo y puede permanecer implantado por hasta 3 años antes de que deba reemplazarse. Hay estudios que muestran que el implante puede ser eficaz por más tiempo del que está aprobado. Debo hablar con un profesional si estoy interesada en usar el método por más tiempo. La mayoría de las mujeres no pueden ver el implante una vez insertado. Es posible que el implante ayude a disminuir los dolores de la menstruación.

La hormona del Nexplanon pasa a la leche materna, por lo que mujeres que están amamantando deben hablar de ello con su profesional de atención médica si desean usarlo.

EFECTOS SECUNDARIOS Y RIESGOS: Sé que mientras uso Nexplanon, puedo tener los siguientes problemas:

- El efecto secundario más frecuente del Nexplanon es una serie de cambios en el patrón menstrual normal que podría incluir sangrado o manchado entre períodos, períodos irregulares, períodos más largos o más cortos, períodos abundantes o leves, o interrupción total de los períodos.
- Además de los cambios en los patrones menstruales, existen otros posibles efectos secundarios, como cambios de humor, depresión, trombosis, aumento de peso, dolores de cabeza, acné o problemas de la piel, dolor o, rara vez, infección en el sitio de la inserción.
- Con Nexplanon, el embarazo es muy poco probable, aunque de producirse, existe una mayor posibilidad de que el embarazo sea ectópico o fuera del útero. Un embarazo ectópico puede causar un sangrado interno grave, incapacidad de quedar embarazada y la muerte.
- Quistes ováricos, que por lo general desaparecen sin tratamiento, pero que en ocasiones se requieren una intervención quirúrgica para extirparlos.
- Complicaciones durante la inserción o extracción de Nexplanon, como irritación, dolor, hinchazón, hematomas, infección, entumecimiento, migración a la vasculatura o cicatrización en el sitio de inserción. Además, es posible que los implantes se rompan o se deformen debido a fuerzas externas (manipulación del implante o deportes de contacto) mientras estén en el brazo de la paciente. El índice de liberación de etonogestrel puede aumentar ligeramente si el implante se dobla o se rompe. Rara vez un implante se sale por sí solo, se rompe durante la extracción o requiere de una intervención quirúrgica para sacarlo.
- Las mujeres con cáncer de mama o antecedentes de este tipo de cáncer no deben usar Nexplanon.

Entiendo que debo regresar a la clínica, a la sala de emergencias del hospital o al consultorio del médico lo antes posible en caso de que ocurra alguna de las siguientes situaciones:

- Si creo que puedo estar embarazada, en especial si tengo alguno de los siguientes problemas, porque podrían ser causados por un embarazo ectópico (embarazo fuera del útero): sangrado vaginal diferente a lo normal, dolor o sensibilidad en la parte inferior del abdomen y desmayos.
- Sangrado menstrual intenso.
- Síntomas de una reacción alérgica grave, como hinchazón de la lengua o garganta, urticaria o dificultad al tragar.
- Dolores de cabeza fuertes o que se intensifican.

- Color amarillento de la piel o de la parte blanca del ojo, especialmente con fiebre, cansancio, pérdida de apetito, orina de color oscuro o heces de color claro.
- Dolor abdominal fuerte.
- Bulto en las mamas.
- Depresión grave.

ALTERNATIVAS: He recibido explicaciones sobre otros métodos anticonceptivos e información por escrito sobre los mismos.

INSTRUCCIONES: He recibido información por escrito sobre Nexplanon que incluye las indicaciones para el paciente aprobadas por la Administración de Alimentos y Medicamentos (FDA). Me han informado y entiendo que se aprobó el uso de Nexplanon por tres años, aunque hay estudios que indican que su eficacia puede durar más tiempo; que si estoy interesada en usarlo por más tiempo, debo hablar de esto con un profesional; y que puedo solicitar que lo retiren antes si así lo deseo. Me han enseñado que puedo sentir el Nexplanon palpando la parte superior de mi brazo. Entiendo que debo contactar a un profesional de atención médica de inmediato si en algún momento no puedo sentir el implante, pues existen reportes de migración del implante.

Me han informado que debo comunicarle a mi profesional de atención médica todos los medicamentos que tomo, tanto los recetados como los de venta libre, porque ciertos medicamentos pueden reducir la eficacia del Nexplanon o éste puede interferir con el efecto de ciertos medicamentos. Me han informado que debo comunicarle a mis profesionales de atención médica que tengo un implante de Nexplanon en el brazo.

También me han dicho que el implante no me protege contra el HIV, el SIDA o demás enfermedades de transmisión sexual. Para una mejor protección contra estas enfermedades, también debo usar condones (preservativos).

DECISIÓN DE INTERRUMPIR EL USO DE NEXPLANON: El uso de este método es totalmente voluntario. Me han informado que tengo derecho a dejar de usar el implante en cualquier momento. Para que me retiren el Nexplanon, debo regresar a la clínica o acudir a un profesional médico calificado. Si tengo problemas para encontrar a un médico calificado, puedo llamar al 1-877-467-5266 para obtener ayuda. La extracción es un procedimiento quirúrgico menor, aunque en ocasiones puede resultar difícil e incluso, raras veces, imposible. Las extracciones difíciles pueden causar dolor y cicatrices, y producir lesiones en los nervios y vasos sanguíneos; además, pueden requerir procedimientos especiales, incluidos métodos de diagnóstico por imágenes para localizar el implante y una cirugía en el hospital. Una vez que se retira el implante, dejo de estar protegida contra embarazaos y debo comenzar a utilizar otro método anticonceptivo de inmediato si no quiero quedar embarazada. Si el implante no se retira, sus efectos pueden continuar.

PREGUNTAS: Me ha dado la oportunidad de hacer preguntas sobre Nexplanon y sobre este formulario de consentimiento y las respuestas han sido satisfactorias.

He leído o me han leído este formulario, entiendo la información que contiene y acepto los riesgos de usar el implante anticonceptivo Nexplanon.

_____	_____	_____
Firma del paciente	Nombre en letra imprenta	Fecha

_____	_____	_____
Firma del orientador	Nombre en letra imprenta	Fecha

El cliente debe firmar este formulario al iniciar o reiniciar este método anticonceptivo, o si se produce un cambio importante en su historia clínica.

Georgia Department of Public Health

Patient Name_____ Date of Birth_____

Health Center Name	**VOLUNTARY CONSENT FOR USE OF THE PARAGARD INTRAUTERINE DEVICE (IUD)**

I am here for insertion of the Paragard IUD. I have voluntarily chosen the IUD as my method of birth control. I understand the ParaGard IUD is made of plastic with copper wire on the plastic. No method can prevent pregnancy 100% of the time. The IUD is a very effective reversible (not permanent) long-term method of birth control that can be as effective as 99.2% in preventing pregnancy. If I decide to stop using the IUD, I know that I must return to a clinic or other heath care professional to have it removed.

BENEFITS: It can stay in place for up to 10 years before replacing. Studies also show that some IUDs can be effective for longer than the time they are approved. I should talk to my provider about this if I am interested in using the method for longer. The ParaGard contains no hormones and can be used while breastfeeding. The IUD causes no interactions with medicines.

SIDE EFFECTS AND RISKS: I know that while using the IUD, I may have the following problems:

- Menstrual changes are common in the first 3 months, including longer and heavier periods
- Bleeding or spotting between periods
- More cramps or pain during periods

Other <u>less common</u> side effects that could occur include:

- Lower abdominal pain and cramping beyond the first 3-5 days after insertion
- Heavy bleeding with my periods. This is more common in people who have bleeding disorders or tend to bleed more than others.
- Perforation (puncture) of the uterus when IUD inserted (very rare); possible increased risk for lactating women (although very low)
- Difficult removal of the IUD which may require surgery (rare)
- IUD may fall out or strings may be difficult to find
- Increased risk of pelvic inflammatory disease (PID), a serious infection of uterus, tubes and ovaries. PID can cause a woman not to be able to have children. This is more common in the first 20 days after insertion and in people who have an STD. My history of STDs and risk factors for coming in contact with an STD may increase my risk.
- If pregnancy does happen while using the ParaGard IUD, there is a greater chance that the pregnancy will be ectopic or outside the womb. Ectopic pregnancy can cause serious internal bleeding, inability to get pregnant and death. However, compared to women not using contraception, women who use an IUD have a much lower risk of ectopic pregnancy.

I understand that I should return to the clinic or seek medical care at a hospital emergency room or doctor's office as soon as possible if I have any of the following:

- Missed period or I think I might be pregnant, especially if have symptoms of ectopic pregnancy or pregnancy outside the uterus, (abnormal vaginal bleeding, lower stomach pain or tenderness and fainting)

- Sex with someone with a sexually transmitted disease or HIV/AIDS
- Missing string or something hard in the vagina or at the cervix (opening of the uterus)
- Increasing or very bad pain in the lower stomach especially if also have fever and/or bleeding between periods or unusual vaginal discharge
- Severe or prolonged vaginal bleeding

ALTERNATIVES: The other methods of birth control have been explained to me and I have been given written information on them.

INSTRUCTIONS: I have been given written information about the ParaGard IUD including manufacturer information for patients. I have been advised that the ParaGard IUD has been approved for 10 years of use and if I am interested in using this longer, I should discuss with my provider. I can have my IUD removed sooner if I want. I understand that I may check the strings to confirm placement if I am interested. I understand that I should return to the clinic for an examination when instructed by my provider.

I have also been told that the IUD does not protect me from HIV/AIDS and/or other sexually transmitted diseases. For better protection from these diseases, I should also use condoms.

DECISION TO STOP USING THE IUD: Using this method is completely voluntary. I have been told that I have the right to stop using the IUD at any time. To do that, I will need to return to the clinic or other qualified medical provider to have it removed. Once the IUD is removed, I am no longer protected against pregnancy and I should start using another method of birth control right away if I do not want to become pregnant.

QUESTIONS: I have been given the chance to ask questions about the IUD and about this consent form and have had all my questions answered to my satisfaction.

I have read this form or have had it read to me, and I understand the information on this form. I accept the risks of using ParaGard.

Patient's Signature	Print Name	Date

Counselor's Signature	Print Name	Date

A client is required to sign this form at the initiation/reinitiation of this contraceptive method or if there is a major change in the health history.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Nombre del paciente _____ Fecha de nacimiento _____

Nombre del Centro de Salud	**CONSENTIMIENTO VOLUNTARIO PARA EL USO DEL DISPOSITIVO INTRAUTERINO (IUD) PARAGARD**

Estoy aquí para que me coloquen el IUD de Paragard. He elegido voluntariamente este IUD como mi método anticonceptivo. Entiendo que el IUD de Paragard está hecho de plástico con alambre de cobre. Ningún método puede evitar un embarazo el 100 % de las veces. El IUD es un método anticonceptivo muy eficaz, reversible (no permanente) y a largo plazo que puede tener un 99.2% de eficacia en la prevención de embarazos. Si decido dejar de usar el IUD, sé que tengo que acudir a una clínica o a otro profesional de la salud para que lo retire.

BENEFICIOS: Se puede usar por hasta diez años antes de reemplazarlo. Los estudios también demuestran que algunos IUD pueden seguir siendo eficaces por más tiempo que el aprobado. Tengo que hablar con mi médico si me interesa usar este método por más tiempo. El Paragard no contiene hormonas y puede usarse mientras se amamanta. Este IUD no tiene interacciones con medicamentos.

EFECTOS SECUNDARIOS Y RIESGOS: Sé que mientras este usando el IUD, puedo tener los siguientes problemas:

- Los cambios menstruales son comunes durante los primeros tres meses, pudiendo caracterizarse por períodos más largos y abundantes.
- Sangrado o manchas entre períodos.
- Más cólicos, calambres o dolor durante los períodos.

Otros efectos secundarios menos comunes incluyen:

- Dolor de vientre, cólicos y calambres más de tres a cinco días después de la colocación del IUD.
- Sangrado abundante durante los períodos, lo que es más común en personas con trastornos hemorrágicos o que tienden a sangrar más que los demás.
- Perforación (agujero pequeño) en el útero al insertar el IUD (muy poco frecuente); el riesgo es mayor (aunque muy bajo) durante la lactancia.
- Dificultad para retirar el IUD, que puede requerir cirugía (muy raro).
- Desplazamiento del IUD o dificultad para encontrar las cuerdas.
- Mayor riesgo de una enfermedad pélvica inflamatoria (PID), que es una infección grave en el útero, las trompas y los ovarios. Una PID puede impedir la concepción en la mujer. Esto es más común durante los primeros 20 días después de la inserción y en mujeres con enfermedades de transmisión sexual (STD). Mi historial de STD y los factores de riesgo por contacto con personas con una STD aumentan mi riesgo.
- Si se inicia un embarazo mientras está usando el IUD Paragard, hay una mayor posibilidad de que el embarazo sea ectópico o fuera del vientre materno. El embarazo ectópico puede causar sangrados internos graves, incapacidad de quedar embarazada y muerte. Sin embargo, comparado con mujeres que no usan ningún método anticonceptivo, las que tienen un IUD corren un riesgo menor de tener un embarazo ectópico.

Entiendo que debo regresar a la clínica o buscar atención médica en la sala de emergencias de un hospital o un consultorio del médico tan pronto como sea posible al enfrentar alguna de las siguientes situaciones:

- Ausencia del período o sospecha de un embarazo, sobre todo si tengo síntomas de un embarazo ectópico o un embarazo fuera del útero, (sangrado vaginal anormal, dolor o sensibilidad en el vientre bajo y desmayos).

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- Relaciones sexuales con una persona que tiene una enfermedad de transmisión sexual, VIH o SIDA.
- Extravío de una de las cuerdas o algo duro en la vagina o en el cuello uterino (apertura del útero).
- Dolor creciente o muy fuerte en el vientre bajo, especialmente acompañado de fiebre o sangrado entre períodos, o un flujo vaginal inusual.
- Sangrado vaginal fuerte o prolongado.

ALTERNATIVAS: ME HAN explicado cómo funcionan los otros métodos anticonceptivos y me han dado información escrita sobre ellos.

INSTRUCCIONES: He recibido información escrita sobre el IUD Paragard, que incluye la información del fabricante para las pacientes. Me informaron que el IUD Paragard fue aprobado para diez años de uso y que si estoy interesada en usarlo por más tiempo, debo hablarlo con mi médico. Puedo solicitar retiren el IUD antes, si así lo deseo. Entiendo que, de estar interesada, puedo revisar las cuerdas del IUD para confirmar que está en su sitio. Entiendo que debo volver a la clínica para un examen, según las indicaciones de mi médico.

También me informaron que el IUD no me protege contra el VIH, el SIDA o demás enfermedades de transmisión sexual. Para una mejor protección contra estas enfermedades, mi pareja debe usar condones.

DECISIÓN DE INTERRUMPIR EL USO DEL IUD: El uso de este método es totalmente voluntario. Me informaron que tengo derecho a dejar de usar el IUD en cualquier momento y que para ello tengo que volver a la clínica o recurrir a otro médico calificado para que lo retire. Al retirar el IUD, dejo de tener protección contra embarazos y debo comenzar a utilizar otro método anticonceptivo de inmediato si no quiero quedar embarazada.

PREGUNTAS: Tuve la oportunidad de hacer preguntas sobre el IUD y sobre este formulario de consentimiento y me las respondieron todas de manera satisfactoria.

Leí o me leyeron este formulario, entiendo la información que contiene y acepto los riesgos de usar el IUD Paragard.

Firma de la paciente	Nombre en letra imprenta	Fecha
Firma del orientador	Nombre en letra imprenta	Fecha

La cliente tiene que firmar este formulario al iniciar o reiniciar este método anticonceptivo, o en caso de un cambio importante en su historia médica.

Georgia Department of Public Health

Patient Name_____ Date of Birth_____

Health Center Name	**VOLUNTARY CONSENT FOR USE OF THE LEVONORGESTREL INTRAUTERINE DEVICE (IUD)**

I am here for insertion of the Levonorgestrel IUD. I have voluntarily chosen the levonorgestrel IUD as my method of birth control. I understand the levonorgestrel IUD is a small, plastic T-shaped device about the size of a quarter, which is placed in the uterus. The levonorgestrel IUD continuously releases levonorgestrel, one of the hormones commonly found in birth control pills. No method can prevent pregnancy 100% of the time. The levonorgestrel IUD is a very effective, reversible (not permanent) long-term method of birth control that can be as effective as 99.9% in preventing pregnancy. If I decide to stop using the IUD, I know that I must return to a clinic or other health care professional to have it removed.

BENEFITS: The levonorgestrel IUD can stay in place for up to 8 years (Mirena and Liletta), 5 years (Kyleena) or 3 years (Skyla) before replacing. Most women have a decrease in the amount of blood that is passed during a menstrual period, and some may not have periods while using the levonorgestrel IUD. There may be less cramping with periods with the levonorgestrel IUD. The levonorgestrel IUD releases a small amount of hormone which passes into the breast milk; it is considered safe with breastfeeding. Women who are breastfeeding and want to use this IUD should discuss this with their health care provider.

SIDE EFFECTS AND RISKS: I know that while using the levonorgestrel IUD, I may have the following problems:

- Menstrual changes are common in the first 3 to 6 months, including longer and heavier periods. Thereafter, periods may be very light or go away altogether.
- Bleeding or spotting between periods
- Cysts on the ovary that usually go away without treatment but sometimes need surgery to remove them

Other <u>less common</u> side effects that could occur include:

- Lower abdominal pain and cramping beyond the first 3-5 days after insertion
- Back pain
- Headaches
- Nausea
- Cramping, dizziness, fainting during insertion
- Breast tenderness
- Mood changes
- Acne or skin problems
- Perforation (puncture) of the uterus when IUD inserted (very rare), increased risk (although very low) for lactating women
- IUD may fall out or strings may be difficult to find
- Increased risk of pelvic inflammatory disease (PID), a serious infection of uterus, tubes and ovaries. PID can cause a woman not to be able to have children. This is more common in the first 20 days after insertion and in people who have an STD. My history of STDs and risk factors for coming in contact with an STD may increase my risk.
- If pregnancy does happen while using the levonorgestrel IUD, there is a greater chance that the pregnancy will be ectopic or outside the womb. Ectopic pregnancy can cause serious internal bleeding, inability to get pregnant and death. However, compared to women not using contraception, women who use an IUD have a much lower risk of ectopic pregnancy.
- Women with breast cancer or a history of breast cancer should not use the Levonorgestrel IUD.

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I understand that I should return to the clinic, hospital emergency room or doctor's office as soon as possible if I have any of the following:

- If I think I might be pregnant, especially if have symptoms of ectopic pregnancy or pregnancy outside the uterus, (abnormal vaginal bleeding, lower stomach pain or tenderness and fainting)
- Fever, flu-like symptoms, or chills
- Sex with someone with a sexually transmitted disease or HIV/AIDS
- Missing string or something hard in the vagina or at the cervix (opening of the uterus)
- Increasing or very bad pain in the lower stomach especially if also have fever and/or bleeding between periods or unusual vaginal discharge
- Severe headaches, or worsening of headaches
- Yellowing of skin or whites of the eyes, especially with fever, tiredness, loss of appetite, dark colored urine or light colored bowel movements
- Had a stroke or heart attack since the levonorgestrel IUD was inserted

ALTERNATIVES: The other methods of birth control have been explained to me and I have been given written information on them.

INSTRUCTIONS: I have been given written information about the levonorgestrel IUD including manufacturer information for patients. I have been advised that the levonorgestrel IUD has been approved for 8 years (Mirena and Liletta), 5 years (Kyleena) or 3 years (Skyla) of use. I can have my IUD removed sooner if I want. I understand that I may check the strings to confirm placement if I am interested. I understand that I should return to the clinic for an examination when instructed by my provider.

I have also been told that the IUD does not protect me from HIV/AIDS and/or other sexually transmitted diseases. For better protection from these diseases, I should also use condoms.

DECISION TO STOP USING THE IUD: Using this method is completely voluntary. I have been told that I have the right to stop using the IUD at any time. To do that, I will need to return to the clinic or other qualified medical provider to have it removed. Once the IUD is removed, I am no longer protected against pregnancy and I should start using another method of birth control right away if I do not want to become pregnant.

QUESTIONS: I have been given the chance to ask questions about the levonorgestrel IUD and about this consent form and have had all my questions answered to my satisfaction.

I have read this form or have had it read to me, and I understand the information on this form. I accept the risks of using the levonorgestrel IUD**.**
I have chosen the following levonorgestrel IUD: ☐ Liletta ☐ Mirena ☐ Skyla ☐ Kyleena.

Patient's Signature	Print Name	Date
Counselor's Signature	Print Name	Date

A client is required to sign this form at the initiation/re-initiation of this contraceptive method or if there is a major change in the health history.

Georgia Department of Public Health

Nombre del paciente _____ Fecha de nacimiento _____

Nombre del Centro de Salud	**AUTORIZACIÓN VOLUNTARIA PARA USAR EL DISPOSITIVO INTRAUTERINO (DIU) DE LEVONORGESTREL**

Estoy aquí para la colocación del DIU de levonorgestrel. He elegido de manera voluntaria utilizar el DIU de levonorgestrel como mi método anticonceptivo. Entiendo que se trata de un dispositivo plástico pequeño con forma de T del tamaño aproximado de una moneda que se coloca en el útero. De manera constante el dispositivo libera levonorgestrel, una de las hormonas que generalmente se encuentra en las píldoras anticonceptivas. Ningún método puede prevenir el embarazo en un 100 %. El DIU de levonorgestrel es un método anticonceptivo muy eficaz, reversible (no permanente) y de larga duración que puede tener una eficacia de un 99.9 % en la prevención de embarazos. Si decido dejar de utilizar el DIU, entiendo que debo regresar a una clínica o visitar a un profesional de la salud para que me lo extraigan.

BENEFICIOS: El DIU de levonorgestrel puede permanecer en su lugar hasta por 8 años en el caso de Mirena y Liletta, 5 años con Kyleena, o 3 años con Skyla, antes de necesitar su reemplazo. La mayoría de las mujeres presentan una disminución en el sangrado menstrual, y algunas pueden no tener períodos menstruales mientras utilizan el DIU de levonorgestrel. Se podrían experimentar menos calambres durante los períodos menstruales con el DIU de levonorgestrel. El DIU de levonorgestrel libera una pequeña cantidad de hormonas que pasa a la leche materna; se considera seguro durante la lactancia. Las mujeres que están amamantando y quieren utilizar este DIU deben discutirlo con su proveedor de servicios médicos.

EFECTOS SECUNDARIOS Y RIESGOS: Entiendo que mientras utilizo el DIU de levonorgestrel, podría presentar los siguientes síntomas:

- Los cambios menstruales son comunes en los primeros 3 a 6 meses, incluidos períodos más largos y abundantes. Luego, los períodos pueden ser leves o desaparecer por completo.
- Sangrado o manchado entre los períodos.
- Quistes ováricos que por lo general desaparecen sin tratamiento, aunque en ocasiones se podría necesitar una intervención quirúrgica para extraerlos.

Otros efectos secundarios menos frecuentes que pueden ocurrir son:

- Dolor abdominal bajo y calambres más allá de los primeros 3 a 5 días después de la colocación.
- Dolor de espalda
- Dolores de cabeza
- Náuseas
- Calambres, mareos, desmayos durante la colocación
- Sensibilidad en las mamas
- Cambios de humor
- Acné o problemas en la piel
- Perforación (punción) del útero cuando se inserta el DIU (muy rara vez), mayor riesgo (aunque es muy bajo) en mujeres lactantes.
- El DIU puede salirse o puede ser difícil encontrar los hilos.
- Mayor riesgo de enfermedad pélvica inflamatoria (EIP), una infección grave del útero, trompas de Falopio y ovarios. La EIP puede provocar que una mujer no pueda tener hijos. Esto es más común en los primeros 20 días luego de la colocación y en personas que tienen una enfermedad de transmisión sexual. Mi historial clínico de enfermedades de transmisión sexual y factores de riesgo por estar en contacto con una enfermedad de transmisión sexual pueden incrementar mi riesgo.
- Si ocurre un embarazo durante el uso del DIU de levonorgestrel, hay una posibilidad mayor de que este sea ectópico o fuera del útero. El embarazo ectópico puede causar sangrado interno grave, incapacidad de quedar embarazada y la muerte. Sin embargo, en comparación con mujeres que no utilizan métodos anticonceptivos, las que utilizan un DIU tienen un riesgo menor de tener un embarazo ectópico.
- Las mujeres que tienen cáncer de mama, o que ya tengan antecedentes, no deberían utilizar el DIU de levonorgestrel.

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Entiendo que debo regresar a la clínica, a la sala de emergencias del hospital o al consultorio del médico lo antes posible en caso de que ocurra alguna de las siguientes situaciones:

- Si creo estar embarazada, en especial, si tengo síntomas de un embarazo ectópico o embarazo fuera del útero (sangrado vaginal anormal, dolor abdominal bajo o sensibilidad y desmayos)
- Fiebre, síntomas gripales o escalofríos
- Relaciones sexuales con alguien que tiene una enfermedad de transmisión sexual o VIH/SIDA
- Pérdida de un hilo o algo duro en la vagina o en el cuello uterino (abertura del útero)
- Dolor muy intenso o en aumento en la parte inferior del estómago, en especial si también se presenta fiebre o sangrado intermenstrual o secreciones vaginales inusuales
- Fuertes dolores de cabeza o intensificación de los dolores de cabeza.
- Coloración amarillenta de la piel o esclerótica, en especial, si presenta fiebre, cansancio, pérdida del apetito, orina de color oscuro o deposiciones claras
- Ha tenido un accidente cerebrovascular o infarto cardíaco desde que se colocó el DIU de levonorgestrel

ALTERNATIVAS: He recibido explicaciones sobre otros métodos anticonceptivos y he recibido información por escrito sobre ellos.

INSTRUCCIONES: Me han proporcionado información escrita sobre el DIU de levonorgestrel, incluida la información del fabricante para pacientes. Me han advertido que el DIU de levonorgestrel ha sido aprobado para utilizarse por 8 años en el caso de Mirena y Liletta, 5 años con Kyleena, o 3 años en el caso de Skyla. Puedo solicitar que me extraigan el DIU antes de tiempo si así lo deseo. Entiendo que puedo revisar los hilos para confirmar su correcta colocación si me interesa. Entiendo que debo regresar a la clínica para ser examinada cuando lo indique mi proveedor.

También me informaron que el DIU no me protege del VIH/SIDA ni de otras enfermedades de transmisión sexual. Para una mejor protección contra dichas enfermedades, también debo usar condones (preservativos).

DECISIÓN DE DEJAR DE UTILIZAR EL DIU: El uso de este método es totalmente voluntario. Me han comunicado que tengo el derecho de dejar de utilizar el DIU en cualquier momento. Para ello, será necesario regresar a la clínica o visitar a otro profesional médico capacitado para que lo remuevan. Una vez removido el DIU, ya no estaré protegida contra el embarazo y deberé comenzar a utilizar otro método anticonceptivo de inmediato si no quiero quedar embarazada.

PREGUNTAS: He tenido la oportunidad de preguntar acerca del DIU de levonorgestrel y sobre este formulario de autorización, y todas mis preguntas se han respondido a mi entera satisfacción.

He leído o me han leído este formulario, y entiendo la información contenida en él. Acepto los riesgos de utilizar el DIU de levonorgestrel.
He elegido utilizar el siguiente DIU de levonorgestrel: ☐ Liletta ☐ Mirena ☐ Skyla ☐ Kyleena.

_____	_____	_____
Firma del paciente	Nombre en letra de molde	Fecha
_____	_____	_____
Firma del representante legal	Nombre en letra de molde	Fecha

El cliente debe firmar este formulario al iniciar o reiniciar este método anticonceptivo o si se produce un cambio importante en el historial clínico.

Key to Family Planning Education and Counseling Form

Purpose

The Key to the Family Planning Education and Counseling Form is a guide to explain the components of each topic area of the Family Planning Education and Counseling Form. Indicating that a specific topic was discussed with a patient means education and/or counseling was provided to the patient as outlined under the topic.

The key is also to ensure consistency and accuracy of the patient information provided. The key is not meant to serve as a substitute for training on topics. Providers should be knowledgeable about all the information they are expected to provide patients.

Education and Counseling

The goal of family planning education and counseling is to assist patients in clarifying personal family planning goals and to promote optimal reproductive health. Interactions with patients should include an assessment of the patient's knowledge, filling in any gaps and correcting misinformation. Patient education and counseling often overlap and distinctions are blurred. While education is usually thought of as transferring information to a patient, counseling is continuum that provides information, advice and guidance. Counseling is less focused on transferring information and more focused on problem solving.

Determining Patient's Understanding

Ways to determine whether a patient understands the information provided or needs further follow-up or reinforcement at the next visit include the following: providing a summary of the information and asking the patient for a summary; checking for clarity with the patient; and asking the patient to explain or repeat key points about what the patient has been told (teach-back technique).

Written Materials

Written materials provided to enhance and support education and counseling should incorporate the principles for using patient-friendly written materials including depth and detail of content, complexity of text, format and user testing. Materials should be reviewed annually to ensure information is current.

Patient Education and the internet

Because many patients use the internet for health information it is important that providers refer patients only to quality sites with information that is accurate, complete, up-to-date and understandable. Studies have shown that most patient education materials on the internet are too difficult for the average reader.

Counseling

- The primary purpose of counseling in the family planning setting is to assist patients in reaching an informed decision regarding their reproductive health and the choice and continued use of family planning methods.
- The counseling process is designed to help patients resolve uncertainty, ambivalence and anxiety about reproductive issues.
- The counseling process enhances the patient's capacity to arrive at a decision that reflects their considered self-interest.

Key to Family Planning Education and Counseling Form

Resources
The resources listed for each topic area are to give the provider basic information on each topic. Other current reputable resources can also be used to guide education and counseling. To follow the link press CTRL while clicking on the link.

Make informed decision about family planning

Resource: Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

- Benefits of family planning in maintaining individual and family health
- Information on all contraceptive methods with emphasis on safest and most effective methods
- Information on long acting reversible contraception
- Advantages/disadvantages/side effects of each method
- How method works
- How well method works (user effective rates)
- What procedures may be required for the method
- How often the method will require follow-up or returning to clinic
- How well each method protects against STIs and HIV

Perform BSE/TSE (Breast Self-Exam/Testicular Self-Exam)

Resources:
http://www.cancer.org/index

- What the exam checks for
- Who should do the exam
- How often to do the exam
- How to perform the exam
- What to do if you find signs/changes from last exam

Understand available services & procedures

Education and counseling

- History, physical, lab testing
- Contraception
- Infertility services
- Treatment for STIs and minor gynecological problems
- Postpartum care
- Referral and follow-up

Key to Family Planning Education and Counseling Form

Understand sequence, purpose and importance of clinic procedures and tests

Resource:

- Education and counseling
- Medical history
- Physical exam
- Tests that may be performed depending on age, history, physical exam findings, method requested; what tests are for; results of tests (when will results will be available, how patient will be notified)
- Discussion of exam and test results
- Method and instructions
- Importance of follow-up of abnormal results and
- How contact will occur if follow-up needed
- Encourage patient to complete lipid testing at a primary care provider's office if at increased risk for cardiovascular disease and over 20 years of age, such as patients with the following: BMI greater than 30, Hypertension, Personal history of coronary artery disease, Diabetes, Family history of early onset heart disease (less than 50 years for males and less than 60 years for females), Tobacco use. For those with hypertension or a history of gestational diabetes, encourage patient to complete screening for type 2 diabetes with a fasting glucose at the patient's primary care provider's office.

Understand risk reduction & Transmission of HIV/STD

Resources:

http://www.cdc.gov/std/prevention/default.htm

Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

- Abstinence
- Vaccinations (HPV, Hepatitis B)
- Reduce the number of sex partners
- Correct, consistent condom use
- Don't share drug equipment
- Testing-know STI and HIV status
- Discussion about personal risks
- Consequences of untreated infections
- Risk reduction and infection prevention information, to address sexual abstinence, mutual monogamy with an uninfected partner, and/or condom use, as appropriate for the patient client
- Referral services
- Need to provide correct information about their risk behaviors, symptoms and the partners

Key to Family Planning Education and Counseling Form

Match reproductive plans to method choice

- What a reproductive plan is
  -A set of personal goals about having (or not having children)
- Components of reproductive plan
  -Whether or not to have children
  -When
  -How many
  -How far apart
  -How to achieve these goals based on personal values and resources
  -Patient's ability to correctly and consistently use preferred method
  -Matching a method to short and long term goals (short acting versus long acting methods such as long acting reversible contraceptives (LARCS)

Sexual abuse/coercion

Resources:
https://www.nij.gov/topics/crime/intimate-partner-violence/teen-dating-violence/Pages/welcome.aspx

- Explanation of what coercion is. Sexual coercion is the act of persuading or coercing a minor into engaging in an unwanted sexual activity through physical force, threat of physical force or emotional manipulation.
- Coercive situations may not be obvious, even to the coerced individual
- Explain that many teens consent to sex without thinking they have a choice
- Coercive situations may involve threats, humiliation, and anger as means to convince a partner to consent to sexual behavior
- You have the right to refuse sex at any time without negative consequences and you have the right to set limits
- The importance of self-esteem and self- respect in avoiding coercive relationships
- Discuss partner violence, date violence, and family violence as well as available resources and/or assistance

Key to Family Planning Education and Counseling Form

Family/parental Involvement

- Explanation of the confidentiality policy
- Explanation that it is the clinic's policy to talk to all adolescents about family involvement
- Allay fears that the clinic does not require family involvement
- Ask whether the adolescent has ever talked to her parent about sex, birth control, STIs
- Be positive about the potential benefits of family involvement (e.g., may provide needed support and care; may promote honesty and trust; may reassure parents that services provided are beneficial, informative and professional; may open the door to future communication)
- Recognize there may be valid reasons a teen may choose not to involve parents (violence in the family, parents with poor communication skills, parents have clearly stated their opposition to seeking services)
- Assist the client in ways that may help parent/teen communication (role playing, brainstorming)
- Promotion of communication between the adolescent and her parent(s) or guardian(s) about sexual and reproductive health

Abstinence

Abstinence is not having sex. However, abstinence can mean different things to different people at different times. It is important not to assume that adolescents are sexually active because they have come for family planning services. As the contraceptive needs of adolescents frequently change, counseling should prepare them to use a variety of methods effectively.

- Many teens (and even adults) choose abstinence for many reasons
- Abstinence is 100% effective in preventing pregnancy
- Avoiding any kind of sexual contact is 100% effective in preventing STIs
- Choosing abstinence can happen at any point in your life, whether you have had sex before or not
- Plan ahead or avoid things that could make abstinence difficult (e.g., peer pressure, strong sexual feelings, pressure from partner, alcohol and drugs)

Adolescent Method Specific Information (on chosen method)

Resources:
Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

http://www.hhs.gov/opa/reproductive-health/

Discussion of method using the current Georgia DPH Consent to Receive Family Planning Services form

- All methods of contraception are an option for adolescents including adolescents who have not been pregnant or given birth
- Description of the method
- How the method works
- How well the method works (when used consistently and correctly and when not used consistently and correctly)

- Benefits
- Side effects and risks
- When patient should seek medical care
- Instructions on how to use the method
- Instructions about stopping the method
- Review of the current method of contraception, plans for contraception &/or review of contraceptive options

Risk reduction/Transmission of HIV/STD and other Infectious Diseases

Resources:
http://www.cdc.gov/std/prevention/default.htm

Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

- Abstinence
- Vaccinations (HPV, Hepatitis B)
- Encouraged Hepatitis C screening at least once in lifetime for all adults aged 18 years and older.
- Reduce the number of sex partners
- Correct, consistent condom use
- Don't share drug equipment
- Testing-know STI and HIV status
- Discussion about personal risks
- Consequences of untreated infections
- Risk reduction and infection prevention information, to address sexual abstinence, mutual monogamy with an uninfected partner, and/or condom use, as appropriate for the patient client
- Referral services
- Need to provide correct information about their risk behaviors, symptoms and the partners

Method Specific Information (on chosen method)

Resources:
Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

http://www.hhs.gov/opa/reproductive-health/

Discussion of method using the current Georgia DPH Consent to Receive Family Planning Services form

- Description of the method
- How the method works
- How well the method works (when used consistently and correctly and when not used consistently and correctly)
- Benefits
- Side effects and risks

- When patient should seek medical care
- Instructions on how to use the method
- Instructions about stopping the method
- Review of the current method of contraception, plans for contraception &/or review of contraceptive options
- Educated all available contraceptive methods including Long Acting Reversible Contraceptives (LARCs)

Preconception health

Health Promotion Strategies for All Reproductive-Age Women

- Nutrition Supplementation
  -Folic acid 0.4mg (400 micrograms) daily and balanced diet that includes folate-rich foods (dark-green leafy vegetables, legumes, peas, fresh fruits)
  -Calcium 1000-1200 mg daily through diet, supplements or combination
  -Vitamin D 400-800 IU through diet, supplements or combination
- Diet and physical activity
- Immunizations

Screenings for All Women of Reproductive Age

- Reproductive plans
- Risks for STIs
- Substance use and substance abuse (tobacco, alcohol, illicit substances)
- Overweight and obesity
- Depression
- Periodontal disease
- Home and work environments

Interventions for women with chronic health conditions

Counseling for women using medications

Basic reproductive anatomy and physiology (depending on client need)

- The male and female reproductive system
- How pregnancy occurs
- Contraception basics

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Immunizations

Resources:
http://www.cdc.gov/vaccines/vac-gen/why.htm

Most current CDC official immunization schedules for preteens, teens and adults are published on the following website **http://www.cdc.gov/vaccines/schedules/**

- Why it is important to get immunized
- Which immunizations may be needed
- How/where can immunizations be obtained

Emergency Contraceptive Pills (ECP)

Resources:
Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

http://www.hhs.gov/opa/reproductive-health/

- Description of ECPs
- How ECPs work
- Effectiveness
  -Should be taken as soon as possible after unprotected sex
  -Can be taken up to 120 hours (5 days). Failure rate slightly higher when taken at 4-5 days
- Benefits
- Side effects and risks
- When to seek medical care
- Instructions on how to use the method
- Starting regular use of contraception after use of ECPs
- Follow-up
- ECP may be offered, if accepted, will be documented in Progress Note

Violence/abuse

Resources:
http://www.womenshealth.gov/violence-against-women/

http://www.cdc.gov/violenceprevention/intimatepartnerviolence/

- What is violence/intimate partner violence/abuse
- Types of violence
- Consequence of abuse/violence
  -Physical
  -Mental health

- Laws
- How to get help

Tobacco use/Quit Line

- Why quit
- Second hand smoke
- How to quit
- Other forms of tobacco, nicotine and marijuana
- Support/resources
- GA Tobacco Quit Line 1-877-270-STOP (Toll free)
- Encourage patient to complete lipid testing at a primary care provider's office if at increased risk for cardiovascular disease and over 20 years of age, such as patients with the following: BMI greater than 30, Hypertension, Personal history of coronary artery disease, Diabetes, Family history of early onset heart disease (less than 50 years for males and less than 60 years for females), Tobacco use. For those with hypertension or a history of gestational diabetes, encourage patient to complete screening for type 2 diabetes with a fasting glucose at the patient's primary care provider's office.

BMI /Healthy Weight

Resources: http://win.niddk.nih.gov/publications/take_charge.htm

- Healthy weight
  -What is a healthy weight
  -What are the health risks of being overweight
  -Why do people become overweight
- Eating healthy
  -What kinds of food should I eat
  -Tips for weight loss
  -Fad diets
- Physical activity
  -How much
  -How do I get started
- Encourage patient to complete lipid testing at a primary care provider's office if at increased risk for cardiovascular disease and over 20 years of age, such as patients with the following: BMI greater than 30, Hypertension, Personal history of coronary artery disease, Diabetes, Family history of early onset heart disease (less than 50 years for males and less than 60 years for females), Tobacco use. For those with hypertension or a history of gestational diabetes, encourage patient to complete screening for type 2 diabetes with a fasting glucose at the patient's primary care provider's office.
- Nutritionist Referral
  -Refer to nutritionist or dietician (if available) if patient has poor dietary intake, is overweight or underweight, is anemic or has any chronic disease related to poor nutrition

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Folic Acid/Multi vitamin

Resources:
http://www.marchofdimes.com/pregnancy/folicacid_indepth.html

- What is folic acid (FA)
- Who needs FA
- How much do I need
- Using contraception and not planning pregnancy (do I still need FA?)
- How can I be sure to get enough
- What foods have FA

Anemia /Fe-rich foods

- What is anemia
- What are types of anemia and causes
- Signs of anemia
- How to find out if you are anemic
- Treatment
- Prevention
  -Iron-rich foods
  -Iron supplements
- Nutritionist Referral
  -Refer to nutritionist or dietician (if available) if patient is anemic

Bone health/Calcium

Resources:
http://www.niams.nih.gov/Health_Info/Bone/Bone_Health/Nutrition/default.asp

http://www.nof.org/learn/prevention

- Bone basics
- What is bone
- Bone density
- Nutrition
  -Calcium rich foods
  -Calcium and Vitamin D
- Lifestyle
  -Exercise
  -Nutrition
  -Smoking and alcohol

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STD/Vaginal Infections

Resources:
http://www.cdc.gov/std/

http://www.hhs.gov/opa/reproductive-health/

- What the infection is
- How common is it
- How do you get the infection
- Signs and symptoms
- Complications
- How is it diagnosed
- Treatment
- Partner instructions
- Prevention

Med instructions (Medication instructions on specific medication)

Resources:
http://www.nlm.nih.gov/medlineplus/druginformation.html

Other reputable sources approved by health district such as Lexicomp

- Why is the medication prescribed
- How should this medication be used
- What special precautions should be followed
- Any special dietary instructions
- What to do if a dose is missed
- Side effects
- When to seek immediate care
- Storage
- What else should I know about this medication

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Abnormal pap/cervical cancer screening

Resources:
http://www.cdc.gov/std/hpv/pap/

http://www.cancer.gov/cancertopics/factsheet/detection/Pap-HPV-testing

- What do the test results mean
- What happens next
- Limitations of cervical cancer screening

Amenorrhea

Resources:
http://www.hhs.gov/opa/reproductive-health/general-reproductive-health/amenorrhea/

http://www.mayoclinic.com/health/amenorrhea/DS00581

- What is amenorrhea
- Symptoms
- Causes
- Tests
- How it is treated

At risk/binge drinking

Resources:
http://kidshealth.org/teen/drug_alcohol/alcohol/binge_drink.html#

http://www.cdc.gov/alcohol/fact-sheets/womens-health.htm

- What is binge drinking
- Why do people binge drink
- What are the risks
- Getting help

Cystitis

Resources:
http://www.hhs.gov/opa/reproductive-health/general-reproductive-health/urinary-tract-infections/

http://www.nlm.nih.gov/medlineplus/ency/article/000526.htm

- What is cystitis

- What are the causes
- How is it treated
- How to prevent cystitis

Douching

Resources:
http://women.webmd.com/guide/vaginal-douching-helpful-or-harmful

- What is douching
- What are the dangers linked to douching
- Should a woman douche
- What is the best way to clean the vagina
- Should I douche to get rid of vaginal odor, discharge, pain, burning or itching

Dysmenorrhea

Resources:
Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

http://www.nlm.nih.gov/medlineplus/ency/article/003150.htm

- What is dysmenorrhea
- How common is it
- What are the causes
- What tests might be done
- Treatment
  -Medications
  -Alternative therapies
- Dysmenorrhea and birth control

Elevated blood pressure

Resources:
http://www.fda.gov/ForConsumers/ByAudience/ForWomen/ucm118529.htm

http://www.mayoclinic.com/health/high-blood-pressure/DS00100

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/High-Blood-Pressure_UCM_002020_SubHomePage.jsp

- What is high blood pressure
- What do the numbers mean
- What does high blood pressure do to your body/complications

- Who is at risk
- Signs
- How is it treated (medication and lifestyle changes)
- Contraception and high blood pressure

Mammogram

http://www.cancer.org/index

- What is a mammogram
- How is it performed
- What are the types of mammograms
- How often should you get a mammogram
- What can it show
- What happens if there is a problem
- How do I get ready for a mammogram/tips

Mental health

Resources:

http://www.apa.org/topics/emotion/index.aspx

http://www.nimh.nih.gov/health/publications/fact-sheets.shtml

- General information about mental health disorder/illness
- Where to get help

Peri-menopause

Resources:
http://www.womenshealth.gov/menopause/

Robert Hatcher et al., Contraceptive Technology, 20th ed., Ardent Media, Inc., New York, 2011

- What is menopause and peri-menopause
- Symptoms
- Menopause and your health
  -Eat well
  -Be active
  -Quit smoking
- Contraception and peri-menopause

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PID (Pelvic Inflammatory Disease)

Resources:

http://www.mayoclinic.com/health/pelvic-inflammatory-disease/DS00402

http://kidshealth.org/teen/infections/stds/std_pid.html

- What is PID
- Causes
- How common is it
- How do you get PID
- Symptoms
- Complications
  -Scarring and reduced chance of pregnancy
  -Ectopic pregnancy
  -Tubo-ovarian abscess
- Tests
- Treatment
- Partner information

Reproductive Coercion

- What is reproductive coercion
- How to get help

Sexual concerns

Resources:
http://www.womenshealth.gov/health-topics/a-z-topic/pubs-orgs.cfm?topic=577

Basic information about the sexual concern
Where to find additional information and help

Substance Use and Abuse (harmful pattern of using substances-tobacco, alcohol, illicit drugs prescription drugs)

Resources:

http://dbhdd.georgia.gov/substance-abuse-prevention

http://www.samhsa.gov/

- What is substance use and substance abuse

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- Signs and symptoms of drug problems and abuse
- How to get help

Referral information

- Provide written information to the referral provider
- Advise regarding patient responsibility in complying with follow-up
- Advise regarding importance of referral and agreed upon method of follow-up
- Provide current list of health care providers or agencies that can be used

Georgia Laws Related to Right of a Minor to Obtain Medical Care Without Consent

The General Rule

In general, consent of a minor's parent or legal guardian is required to obtain or refuse medical care. [O.C.G.A. §§ 31-9-2(a) and 31-9-7]. This is not an absolute rule and there are various circumstances where consent by a parent or legal guardian may not be required. Below are examples of common exceptions to the general rule.

Exceptions to the General Rule

Emancipation
A minor who is emancipated may consent to or refuse medical care [O.C.G.A. § 15-11-727].

There are four ways for a minor to become emancipated under Georgia law:

- A minor is emancipated upon being validly married
- A minor is emancipated while serving on active duty with the United States armed forces
- A minor is emancipated upon reaching the age of 18
- A minor is emancipated when a court issues an order of emancipation is issued by a juvenile court

Emergency Situations
Parental consent is not required to provide medical care in an emergency, defined as a situation in which treatment is reasonably necessary and delay to obtain consent from the parent could reasonably be expected to jeopardize health or life, or result in disfigurement or impairment. [O.C.G.A. § 31-9-3(a)]. Abortion and sterilization are not considered emergency situations. [O.C.G.A. § 31-9-5].

Guardians
A legal guardian to a minor may consent to medical treatment on behalf of that minor. [O.C.G.A. § 31-9-2(a)(4)]. Several types of guardians are recognized under Georgia law, including court-appointed guardians. [*See, e.g.*, O.C.G.A. § 29-4-18 (court-appointed "temporary medical consent guardian")].

Georgia law also permits consent to be given by "any person temporarily standing in loco parentis . . . for the minor under his or her care." [O.C.G.A. 31-9-2(a)(4)]. "In loco parentis" means an adult is acting in place of the parents, but who does not necessarily have a court appointment. An example would be someone taking care of a child whose parents reside in another country.

Pregnancy and Birth Control
Parental consent is not required to provide treatment to a female of any age "in connection with pregnancy, or the prevention thereof, or childbirth." [O.C.G.A. 31-9-6(a)(5)]. This includes birth control measures such as birth control pills and IUDs. However, it does not include abortion or sterilization. [O.C.G.A. 31-9-5].

Sexually Transmitted Disease (STDs)
Parental consent is not required to test or treat a minor for sexually transmitted diseases, including HIV/AIDS. [O.C.G.A. §§ 31-17-3 and 31-17-7].