

Patient Consent Form for the Insertion of IMPLANON NXT®

Med Rec No.	-----
Patient name	-----
DOB	-----

Overview of treatment

The insertion of IMPLANON NXT® involves a small plastic implant containing the hormone progesterone being inserted underneath the skin of the upper inner arm to act as a contraceptive against pregnancy for up to three years.

Pre Insertion Section

Patient to tick boxes

Benefits and risks	<p>I have discussed the benefits, risks and side effects of using IMPLANON NXT® with my doctor. Side effects may include:</p> <ul style="list-style-type: none"> irregular bleeding, no bleeding, headaches, weight gain and breast symptoms bruising and discomfort for up to one week after insertion the possibility of allergic reactions the implant moving from its original position, which could make removal more difficult. 	<input type="checkbox"/>
Effectiveness of contraception	I am aware of the effectiveness of IMPLANON NXT® as well as its relative effectiveness compared with other birth control methods. I am aware no birth control method is completely reliable so I could have a small chance of becoming pregnant	<input type="checkbox"/>
Removal after three years	I understand that the IMPLANON NXT® implant must be removed by three years since leaving it in place for longer may increase the chances of an ectopic pregnancy (pregnancy in the tube). I am aware it is my responsibility to arrange removal	<input type="checkbox"/>
Scarring	The insertion and removal of the Implant may leave a small scar on the skin. I am aware that some people are predisposed to develop a thickened scar. A larger scar is likely if the IMPLANON NXT® implant is difficult to remove	<input type="checkbox"/>
Insertion and removal	I understand that to reduce discomfort, my doctor will use a local anaesthetic when inserting and removing the IMPLANON NXT® implant	<input type="checkbox"/>
Allergic reactions	I have advised my doctor of any known allergies, especially allergies to a local anaesthetic, sex hormones, plastics, metals, latex or any of the active or inactive ingredients or excipients contained in IMPLANON NXT®	<input type="checkbox"/>
Acknowledgement	I have understood the information concerning IMPLANON NXT®. I will contact my doctor should I require further advice	<input type="checkbox"/>
Interactions	I understand that I must advise my doctor of any medication I am taking, as well as advise any other doctors I see, that I have an IMPLANON NXT® implant, as these can reduce the effectiveness of IMPLANON NXT®	<input type="checkbox"/>

Based on the information above, I _____ willingly consent for my doctor to insert an IMPLANON NXT® implant for use as a contraceptive in my Left/ Right arm. By ticking off each of the items above, I acknowledge that these are understood by me and have been discussed with my doctor.

Signed by patient _____ Date ____/____/____

Post Insertion Section

Outcome

<ol style="list-style-type: none"> I can feel the inserted implant. I have a copy of the Consumer Medicine Information and the post insertion care instructions I should return to see my doctor if I have any concerns or questions I should have an annual check up while the implant is inserted. I need to have the implant removed in 3 years time. 	<p>_____ Date ____/____/____</p> <p>Signed by Patient</p>
	<p>_____ Date ____/____/____</p> <p>Signed by Doctor</p>