UVA Health

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME &MR#

CONSENT FOR NEXPLANON® IMPLANT

A. CONSENT FOR PROCEDURE

1. I authorize_____to perform the following procedure(s):

NEXPLANON (ESTONOGESTREL) IMPLANTS

I understand the Patient Labeling for NEXPLANON®. I have discussed NEXPLANON® with my healthcare provider who answered all my questions. I understand that there are benefits as well as risks with using NEXPLANON®. I understand that there are other birth control methods and that each has its own benefits and risks.

I also understand that this Patient Consent Form is important. I understand that I need to sign this form to show that I am making an informed and careful decision to use NEXPLANON®, and that I have read and understand the following points.

- NEXPLANON® helps to keep me from getting pregnant.
- No contraceptive method is 100% effective, including NEXPLANON®.
- NEXPLANON® has an implant that contains a hormone.
- It is important to have the NEXPLANON® implant **placed in my arm** at the right time of my menstrual cycle.
- **After the implant is placed in my arm, I should check that it is in place by gently pressing my fingertips over the skin where the implant was placed. I should be able to feel the implant.**
- The implant must be removed at the end of three years. The implant can be removed sooner if I want.
- If I have trouble finding a healthcare provider to remove the implant, I can call 1-877-467-5266 for help.
- The implant is placed under the skin of my arm during a procedure done in my healthcare provider's office. There is a slight risk of getting a scar or an infection from this procedure.
- Removal is usually a minor procedure. Sometimes, removal may be more difficult. Special procedures, including surgery in the hospital, may be needed. Difficult removals may cause pain and scarring and may result in injury to nerves and blood vessels. If the implant is not removed, its effects may continue.
- **Most women have changes in their menstrual bleeding patterns while using NEXPLANON®. I also will likely have changes in my menstrual bleeding pattern while using NEXPLANON®. My bleeding may be irregular, lighter or heavier, or my bleeding may completely stop. If I think I am pregnant, I should contact my healthcare provider as soon as possible.**
- I understand the warning signs for problems with NEXPLANON®. I should seek medical attention if any warning signs appear.
- I should tell all of my healthcare providers that I am using NEXPLANON®.
- I need to have a medical check regularly and at any time I am having problems.
- NEXPLANON® does not protect me from HIV infection (AIDS) or any other sexually transmitted diseases.

(CONTINUED ON NEXT PAGE)

UVA Health

0100000

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME &MR#

B. CONSENT FOR ANESTHESIA OR SEDATION

1. When local anesthesia and/or sedation is used by the physician on page one, Section A1:

I consent to the administration of such ***local anesthetics*** as may be considered necessary by the physician in charge of my care. I understand that the risks of local anesthesia include: local discomfort, swelling, bruising, allergic reactions to medications, and seizures.

I consent to the administration of ***sedative medications*** by or under the direction of the physician named in Item A1 or the physician in charge of my sedation care. I acknowledge that I have been informed of the nature of the planned sedation and that I understand the risks of sedation to include: allergic reactions to medications, changes in breathing, changes in blood pressure and heart function, nausea and vomiting, aspiration of stomach contents and/or excitement. I understand that recall of the procedure is possible.

---

2. When regional anesthesia, general anesthesia, or monitored anesthesia care is provided by the personnel in the **Department of Anesthesiology:**

I consent to care provided by the physicians of the Department of Anesthesiology. I acknowledge that the anesthesia may actually be administered by a physician in training (resident) or nurse anesthetist under the direction of the anesthesiologist who is assigned to care for me. The anesthetic technique may be a general anesthetic ("being put to sleep") and/or a nerve block. I understand that the risks of anesthesia include: sore throat and hoarseness, nausea and vomiting, aspiration of stomach contents, muscle soreness, injury to the eyes, injury to the gums or lips, damage to the teeth or dental work, allergic reactions to medications, recall of procedure, changes in breathing, changes in blood pressure and heart function, nerve injury, cardiac arrest, brain damage, paralysis, or death.

Additional information regarding the various forms of anesthesia and pain control, risks, and options is available from the anesthesiologist directing your care.

C. PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

By signing below I state that I am 18 years of age or older, or otherwise authorized to consent. I have read or have had explained to me the contents of this form and I agree to receive the care, treatment or services listed on this consent. I have had a chance to ask questions and all of my questions have been answered.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | PRINTED NAME | DATE | TIME

IF SIGNED BY PERSON OTHER THAN THE ADULT PATIENTCHECK RELATIONSHIP TO PATIENT:

☐ 1. Agent Named in Advance Directive ☐ 4. Adult Child ☐ 6. Adult Brother/Sister
☐ 2. Guardian ☐ 5. Parent ☐ 7. Blood Relative
☐ 3. Husband/Wife ☐ 8. Other* _____

FOR Minor PATIENTS:

☐ 1. Parents ☐ 2. Guardian or Legal Custodian ☐ 3. Authorized person for child in out-of-home placement
☐ 4. Authorized to consent as an adult for this procedure

***Requires review and appointment by Ethics Consult Service. See Medical Center Policy 024, Informed Consent.**

D. PHYSICIAN STATEMENT/SIGNATURE & WITNESS SIGNATURE:

I have explained the procedure(s) stated on this form, including the possible risks, complications, alternative treatments (including non-treatment) and anticipated results to the patient and/or his/her representative. The patient and/or their representative has communicated to me that they understand the contents of this form.

SIGNATURE OF PHYSICIAN OR DESIGNEE OBTAINING CONSENT | PRINTED NAME | PIC # | DATE | TIME

SIGNATURE OF WITNESS (OPTIONAL) REQUIRED FOR TELEPHONE CONSENTS | PRINTED NAME | DATE | TIME

E. INTERPRETER ATTESTATION (when applicable)

Interpretation has been provided by:

SIGNATURE OF INTERPRETER/CYRACOM ID# | PRINTED NAME | DATE | TIME