

Place Patient Label Here

**Request and Consent for
Depo Provera® (The Shot)**

Voluntary Participation and Confidentiality Statement: Title X services are being provided to me solely on a voluntary basis; I am choosing to receive these services of my own free will. I understand that staff may not coerce (force) me to receive services, to use, or not to use any particular method of family planning. I understand I have the right to accept or refuse family planning services without being denied eligibility for any other services/programs provided by this agency. This information is confidential and will be treated as such.

Birth control methods may have good or bad side effects or complications, which may be harmful to me. I have been told that the most frequent benefits, risks and side effects are those listed below. Others not listed may occur.

Depo Provera Use Effectiveness: 96–99.7 Percent

Benefits	Possible Risks/Disadvantages	Possible Side Effects
1. Contraception lasts three months	1. Pain at injection site	1. Altered menstrual periods
2. No estrogen, progestin-only	2. Menstrual cycle changes	2. Weight gain
3. Relief of menstrual cramps	3. Bone mineral density changes	3. Depression, fatigue or nervousness
4. Less blood loss during periods	4. No protection against sexually transmitted infections, including HIV	4. Breast discomfort
5. Protective effect against pelvic inflammatory disease (PID)	5. Delayed return to fertility; average with regular use: nine to ten months after last shot	5. Headaches
6. Reduced risk of ectopic pregnancy	6. Return visits required every three months	6. Allergic reactions (rare)
7. May have fewer seizures		
8. Fewer sickle cell crises		
9. Less pain from endometriosis		
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1. I do not wish to become pregnant now. One benefit of choosing a method of birth control is that I will be better able to delay a pregnancy until it is desired.
2. The contraceptives that I am interested in have been explained to me. I may change to another method or stop using a birth control method at any time I wish, for any reason, including if I wish to become pregnant or if medically recommended. Instructions for the use of my chosen method have been given to me.
3. I understand that to continue the use of Depo Provera[®], I must come to the clinic for a check-up and shot every three months. It is my responsibility to schedule my shot appointments every three months (13 weeks). After three months, if I do not get another shot, the Depo Provera[®] effects will decrease and I may become pregnant.
4. I have read the above (or have had it read to me) and have been given the opportunity to ask questions and received answers to my satisfaction. Being mentally competent, I assume full responsibility and release the local health department, including the attending clinician, staff and assistants of any and all liability for any adverse effects or pregnancy that may result from my using the method of birth control provided to me. I have been advised to call the clinic for discontinuation instructions if I choose to stop this method.
5. I have been provided with information about an emergency number to call after clinic hours or when the agency is closed.
6. I have chosen and requested Depo Provera[®] as a method of birth control.

____/____/____
Date

Signature of Patient

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual in choosing a birth control method:

I have translated the information and advice presented orally to the patient to use the above contraception by the person obtaining this consent. I have also read the patient the consent form in _____ language and explained its contents. To the best of my knowledge and belief, the patient understood this explanation.

Interpreter

____/____/____
Date