

Consent to a fitting or refitting of a contraceptive implant

Name:

Date of Birth:

Affix patient
label here

I AGREE TO THE FOLLOWING;

I have been counselled about the Contraceptive Implant and the fitting procedure today.

I understand the risks associated with the fitting of a Contraceptive Implant;

Pain

Bleeding, bruising and haematoma

Wound infection

Scarring

Damage to nerves and blood vessels with 1/100,000 risk of distant implant migration

Reaction to local anaesthetic

Failure to fit or remove the device

I have been told when the device will need to be changed and how to care for my wound.

Patient

SignatureDate.....

Clinician

Signature.....Date.....