

Consent to removal of a contraceptive implant

Name:

Date of Birth:

Affix patient
label here

I AGREE TO THE FOLLOWING;

I have been counselled about the process for removal of a Contraceptive Implant.

I understand the risks associated with the removal of a Contraceptive Implant:

Pain

Wound infection

Scarring

Bleeding and bruising

Damage to nerves and blood vessels

Reaction to local anaesthetic

Failure to remove the implant

I have been told how to care for my wound.

Patient

SignatureDate.....

Clinician

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