**Spring Gardens Health Centre**

**Consent for Subdermal Progestogen Contraceptive Implant**

**Name:**

**I hereby consent myself for fitting/removal of a subdermal contraceptive implant, the nature, effects and risks of which have been explained to me by:**

**Doctor…………………………………………………..**

**I understand that:**

1. My menstrual periods may be infrequent (one third of users), or prolonged and frequent (one quarter of users). Some will have no periods (one fifth of users). Fewer than one quarter of women using the implant will have regular bleeds. Altered bleeding patterns are likely to remain irregular.
2. No routine follow up is required, but I can return if any problems and should return if I cannot feel implant, it appears to have changed shape, I notice any pain or skin changes around site of implant or I become pregnant. If I start any new medication I should tell my doctor that I have an implant.
3. The implant is highly effective <1/1000 pregnancy rate over 3 years.
4. The main risks are non insertion of the implant, deep insertion or migration( 1/1000000 chance of migration via a blood vessel to heart or lungs), which can require surgery to remove it. There is a rare risk of nerve or vascular damage. There is a small risk of infection, bleeding, scarring and irritation around insertion site.
5. Mild discomfort and bruising is normal after insertion and removal of implant.
6. Extra precautions (e.g. condoms) for 7 days after insertion are usually required.
7. I still need to use condoms if I want to prevent the risk of sexually transmitted diseases.
8. I need to assume fertility has returned as soon as implant is removed.
9. The implant lasts for 3 years, after this date it cannot be relied on for contraception.
10. I am not aware of any reason why I should not use the contraceptive implant (such as pregnancy, liver disease, breast cancer or allergies to the device or local anaesthetic).
11. **I need to make a note of the date when my implant needs to be changed as the practice does not send out a reminder.**

**Patient’s Signature:…………………………………………………**

**Doctor’s signature:………………………………………………… Date:………………………**