

# INFORMED CONSENT FOR EMERGENCY CONTRACEPTION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

***Before giving your consent, be sure that you understand both the pros and cons of Emergency Contraception (EC). If you have any questions, we will be happy to discuss them with you. Do not sign your name at the end of this form until you have read and understood each statement. This information is confidential.***

I understand that:

- Emergency contraceptive pills (ECP's) contain the same medication as regular birth control pills and can help prevent pregnancy. These pills are taken after having unprotected sex (if my regular birth control fails or I have sex without birth control).
- EC is for emergency use only. It should not take the place of regular birth control methods, such as the "pill", condoms, the birth control patch or shot, etc.
- EC can work by stopping the release of an egg from the ovary (ovulation), or it may prevent the union of sperm and egg (fertilization), or it may prevent a fertilized egg from attaching to the womb (implantation). EC will not work after implantation of a fertilized egg. EC will not disrupt an established pregnancy.
- It is best to use EC within 3 days of having unprotected sex. New information shows that EC may sometimes prevent pregnancy up to five days after sex, but EC works better the sooner you use it.
- EC is not 100 percent effective.
- Reactions to the pills may include nausea, vomiting, headache, stomach pain, dizziness, breast tenderness, early or late menstrual period.
- I should see a physician if my period has not started within 3 weeks after treatment.
- I should use a regular method of birth control to prevent pregnancy if I have sex before my next period.
- EC will not protect me from or treat sexually transmitted diseases, including HIV/AIDS.
- No guarantee or assurance has been made to me as to the results of using ECP's.
- I knowingly request that the authorized pharmacist, whose signature appears below, provide me with ECP's.

**I have read and understand all of the above information.**

**Yes**

**No**

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Pharmacist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_