*(Clinic Name)*

*(Clinic Contact Information)*

Intrauterine Device (IUD) Removal Consent

Name _____________________________________________DOB________Chart No.______________

_____I am requesting to have my Intrauterine Device (IUD) taken out today.

_____I have been informed and understand that I may become pregnant right after the IUD is taken out. If I do not want to get pregnant after the IUD is taken out, I may have a new IUD put in today or choose a different method of birth control to start today.

_____I have been informed and understand what will happen before, during and after the IUD is removed.

_____ I have been informed and understand that if the provider is unable to remove my IUD, I may be referred to another provider who can do an ultrasound and remove the device using another method. I understand every effort will be made to refer me to another provider that offers a sliding fee discount scale, however I may be financially responsible to that provider.

_____I have been informed and understand that I may have some bleeding, cramping or pain with the IUD removal procedure and it may continue for a short time afterward.

_____This form has been fully explained to me, I have read it or have had it read to me, and I understand its content. I have had the chance to ask questions. All of my questions and concerns have been answered. I have also been offered other requested contraceptive services or preconception health as indicated. I further understand my responsibility to call the clinic with any questions or concerns.

_____I have read and understand this form and would like to proceed having my _________________

IUD removed today.

Client name (printed)________________________________________________

Client signature_____________________________________________________Date_______________

Clinician witness signature____________________________________________Date_______________