Intrauterine Device Consent

I received the information and asked all my questions about:

___ ParaGard  ___ Mirena

I know that:

• The IUD prevents pregnancy more than 99% of the time. It provides long term protection from pregnancy.
• Each ParaGard IUD is good for 10 years of use. Each Mirena IUS is good for 5 years of use.
• Mirena IUD contains the hormone progestin and may decrease menstrual bleeding and cramps.
• The IUD does not protect me from sexually transmitted infections. If I need this protection, I will use condoms PLUS this method.

I know the IUD might cause the following:

• Spotting, irregular bleeding, heavier periods;
• Cramping when it is put in at the clinic and during my periods;
• Making a hole in the wall of the uterus when it is put in at the clinic;
• String may not be found at future visits, or other string problems.

My health care provider has told me the following reasons why a person should not use the IUD:

• Current Pelvic infection (PID) or high risk for sexually transmitted infections;
• Current pregnancy or suspicion of current pregnancy;
• Known or suspected uterine/cervical cancer; or breast cancer (for Mirena);
• Wilson’s disease;
• Allergy to copper (for ParaGard);
• Uneven shape of the uterus.

I will call the clinic or my private doctor, or go to the emergency room if I have any of these danger signs:

• Late or missed period; abnormal spotting or bleeding; signs or symptoms or pregnancy;
• Pelvic or lower abdominal pain; pain with intercourse;
• Exposure to sexually transmitted infections; abnormal vaginal discharge;
• Fever or chills;
• Cannot locate the string;
• The IUD has come part of the way out, or all the way out, of the uterus.

If I have problems or concerns, I will come back to the clinic to talk with a nurse or doctor to see if I can make the IUD work for me. If I wish to stop using the IUD, I know that I need to come back to the clinic to have it taken out. If I do not wish to become pregnant, I must start on another method right away.

______________________________________________________________  __________
Patient signature                                               Date

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______________________________________________________________  __________
Physician Signature                                             Date