Consent for Nexplanon Implant Insertion / Removal / Replacement

(this form is for Implant Insertion / Removal / Replacement - please only complete the section(s) relevant to your procedure)

Patient Name:

Date of Birth:

NHS Number:

Implant Insertion

Current contraception:	First Day of Last Period:
Date of Last Intercourse:	Allergies:

Risks	
Discomfort at Insertion / Use of Anaesthetic	☐
Bruising / Infection / Small scar	☐
Insertion Failure/ Migration	☐
Difficulty in removing Implant	☐
Pregnancy (<1 in 1000 over 3y)	☐

Benefits	
Contraception (3-year Method) Failure rate in 1st year <1 in 1000	☐

Side Effects	
Irregular/prolonged/absent periods	☐
Headaches	☐
Breast tenderness	☐
Acne	☐
Weight Gain	☐
Mood change	☐

Chlamydia Screen (for patients aged 15-24)	
Would you like a Chlamydia test?	☐
If not screened, please state reason	
Recently tested	☐
Inappropriate (As no change of sexual partner)	☐
Declined	☐
Other (please specify)	☐

Implant Removal

Risks	
Discomfort at Removal / Use of Anaesthetic	☐
Bruising / Infection / Small scar	☐
Removal technique	☐
Return to Fertility	☐

Statement of Health Professional

I have explained the procedure to the patient and discussed the above risks and benefits.

Doctor:	Signature:	Date:

Statement of Patient

I consent to insertion and/or removal (delete as appropriate) of Contraceptive Implant (Nexplanon). The above risks and benefits have been explained to me, and I have had the opportunity to ask any questions I might have.

I understand that any procedure in addition to those described above will only be carried out if necessary to save my live or prevent any serious harm to my health.

Patient:	Signature:	Date: