Dr. Martin O'Flynn Dr. Laura O'Flynn Dr. Niall Breen

Providing the best standard of medical care for the community of Portmarnock & beyond

Implanon Patient Consent Form

Name: ___________________________________

DOB: ____________________________________

Date of Birth______________________________

Inserted by_________________________________

Date of Insertion___________________________

Benefits and risks	I have discussed the benefits, risks and side effects of using IMPLANON NXT® with my doctor. Side effects may include: • irregular bleeding, no bleeding, headaches, weight gain and breast symptoms • bruising and discomfort for up to one week after insertion • the possibility of allergic reactions • the implant moving from its original position, which could make removal more difficult.	☐
Effectiveness of contraception	I am aware of the effectiveness of IMPLANON NXT® as well as its relative effectiveness compared with other birth control methods. I am aware no birth control method is completely reliable so I could have a small chance of becoming pregnant	☐
Removal after three years	I understand that the IMPLANON NXT® implant must be removed by three years since leaving it in place for longer may increase the chances of an ectopic pregnancy (pregnancy in the tube). I am aware it is my responsibility to arrange removal	☐
Scarring	The insertion and removal of the Implant may leave a small scar on the skin. I am aware that some people are predisposed to develop a thickened scar. A larger scar is likely if the IMPLANON NXT® implant is difficult to remove	☐
Insertion and removal	I understand that to reduce discomfort, my doctor will use a local anaesthetic when inserting and removing the IMPLANON NXT® implant	☐
Allergic reactions	I have advised my doctor of any known allergies, especially allergies to a local anaesthetic, sex hormones, plastics, metals, latex or any of the active or inactive ingredients or excipients contained in IMPLANON NXT®	☐
Acknowledgement	I have understood the information concerning IMPLANON NXT®. I will contact my doctor should I require further advice	☐
Interactions	I understand that I must advise my doctor of any medication I am taking, as well as advise any other doctors I see, that I have an IMPLANON NXT® implant, as these can reduce the effectiveness of IMPLANON NXT®	☐

Based on the information above, I ________________________________ willingly consent for my doctor to insert an IMPLANON NXT® implant for use as a contraceptive in my Left/ Right arm. By ticking off each of the items above, I acknowledge that these are understood by me and have been discussed with my doctor.

Signed by patient ___________________________ Date ___/___/______

Post Insertion Section

Outcome

1. I can feel the inserted implant. 2. I have a copy of the Consumer Medicine Information and the post insertion care instructions 3. I should return to see my doctor if I have any concerns or questions 4. I should have an annual check up while the implant is inserted. 5. I need to have the implant removed in 3 years time.	________________ **Date** ___/___/______ **Signed by Patient** ________________ **Date** ___/___/______ **Signed by Doctor**