

Consent for Examination

DeKalb County Health Department
Family Planning Program

CONSENT FOR EXAMINATION

In order for the Family Planning Program to supply a prescription for contraception, a medical history and examination must be performed at the first visit and once a year thereafter. The examination may include:

- Height, weight and blood pressure
- Urinalysis (for sugar and protein) at first exam only
- Hemoglobin blood test (a finger stick to detect low iron or anemia)
- Heart, lung and thyroid exam
- Breast exam with review in breast self-exam or breast awareness
- Pap smear (for cervical cancer) if indicated
- Pregnancy testing if indicated
- Abdominal exam
- Pelvic exam
- Rectal exam

The following tests are **not** routinely included, but may be done if indicated. You will be advised if any of these tests are recommended.

- Sexually transmitted infection testing
- Vaginal infection testing

HIV/AIDS testing is not done with your exam. If it is determined that you are at risk for HIV/AIDS the family planning staff will give you referral information.

Fecal occult blood testing will be offered to you if it is determined that you are at risk for cancer of the colon or rectum due to age, medical history, family history, or symptoms.

We prescribe Emergency Contraception (sometimes called "the morning after pill") a woman has up to 120 hours, 5 days after unprotected sex to take Emergency Contraceptive pills. We will provide in advance of need, if you are interested be sure to ask.

Confidentiality will be maintained on all of your records and conversations at the Health Department. Information or records will only be released to others with your written consent, except when necessary to provide other services, or as required by law, with appropriate safeguards for confidentiality.

If any tests which are sent out to another lab (Pap and STD tests) come back abnormal, the Family Planning Nurse will need to notify you. Please make certain that you have provided us with information needed to contact you or you may call us back ten days to two weeks after your exam to check these test results. Please ask any questions you have regarding the above information.

By signing this consent I agree to the release of necessary medical information to the Illinois Breast & Cervical Cancer Program for evaluation and treatment of any abnormal pap or breast exam findings if I qualify for these services.

I verify that I have read and understand the information contained in this consent form and I voluntarily consent to and request an examination at this time. I also consent for examination and/or treatment of problems that may occur between now and my next comprehensive annual examination and I am aware that I also have the right to change my mind at any time. I authorize the DeKalb County Health Department to use the information gained during treatment to bill me or other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I acknowledge that I have received a copy of the HIPPA Notice of Privacy Practices of the DeKalb County Health Department.

Signed _____ Date _____

Witness _____ Date _____

DeKalb County Health Department
Family Planning Program

CONSENT FOR EXAMINATION
Annual Revisit (Re-sign Annually)

I have reviewed the information contained in this consent form and request an examination at this time.

Signed _____ Date _____

Witness _____

I have reviewed the information contained in this consent form and request an examination at this time.

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