**Informed Consent for Emergency Contraception**

Name_____Age_____

Address _____Phone (  ) _____

First day of last menstrual period ___/__/__ Date of unprotected intercourse ___/__/__
mo/day/yr mo/day/yr

***Before giving your consent, be sure that you understand both the pros and cons of Emergency Contraception (EC). If you have any questions, we will be happy to discuss them with you. <u>Do not sign</u> your name at the end of this form until you have read and understood each statement and the pharmacist has answered your questions and can witness your signature. This information is confidential.***

**I understand that:**

- EC contains hormones that act to prevent pregnancy. These pills are taken after having unprotected sex (sex without birth control or a birth control failure). They are to be used as an emergency treatment only and not as a routine method of contraception.
- EC works by preventing or delaying the release of an egg from the ovary, preventing fertilization, or causing changes in the lining of the uterus that may prevent implantation of a fertilized egg. I understand that if I am already pregnant, EC will not stop or interfere with the pregnancy.
- EC treatment should be started within 5 days (120 hours) of unprotected sex.
- EC is not 100 percent effective.
- Reactions to the pills may include nausea and vomiting, fatigue, dizziness, breast tenderness, early or late menstrual period.
- I should see a health care provider or have a pregnancy test if my period has not started within 3 weeks after treatment.
- I should use condoms, spermicides, or a diaphragm, or continue taking birth control pills to prevent pregnancy if I have sex before my next period. After that, I should continue to use a method of contraception.
- EC will not protect me from nor treat sexually transmitted diseases, and I should seek diagnosis and treatment if I am concerned about this.
- I understand that it may be useful to share this treatment information with my regular health care provider. Therefore, I request and authorize the release of this information to the following designated provider.

**Yes_____ No_____ Designated Provider's Name _____**

Patient's Signature _____Date _____

Pharmacist's Signature _____Date _____

*New Mexico Pharmaceutical Association recommended form (EC-1 May 2—3)*