

ACAP Health Services Informed General Consent
Aroostook County Action Program

I voluntarily seek reproductive health services which may include contraceptive methods, sexuality and STI education, physical examination, tests and treatments as needed.

I have been informed of the methods of birth control available to prevent pregnancy and their risks and benefits. I have been provided with written instructions for the use of the method I have chosen. I have been given the opportunity to ask questions about birth control methods, hormone replacement methods, the procedures and treatment offered and this consent form.

I am aware that all or part of my medical care will be provided by a nurse practitioner or attending clinician during this and subsequent visits to this clinic. If any medical problem is detected, referral will be made to a physician of my choice and I will assume responsibility for obtaining and paying for this care.

I understand that the examination procedure includes, but is not limited to:

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| ▪ Blood Pressure Check | ▪ Height | ▪ Vaginal culture as needed |
| ▪ Pap test for cervical/vaginal cancer | ▪ Breast Exam | ▪ Blood test for glucose as needed |
| ▪ Weight | ▪ Rectal Exam as needed | ▪ Endometrial sampling as needed |
| ▪ Urinalysis | ▪ Gonorrhea test as needed | ▪ Blood test for hemoglobin as needed |
| ▪ Pelvic exam | ▪ Chlamydia test as needed | |

I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees have been made to me concerning the effectiveness of the use of birth control method I have chosen or the procedures and treatment provided to me.

I understand the importance of regular check ups and intend to keep my appointments as scheduled. ***It is my responsibility to contact the health center if I find it necessary to cancel.***

<p>Minors I have been counseled regarding the importance of discussing my participation in the ACAP Health Services program with my parents or guardian. I feel <input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT able to discuss this with them.</p> <p>They <input type="checkbox"/> DO <input type="checkbox"/> DO NOT know of my involvement with ACAP Health Services If not, do you plan to discuss this with them in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____</p> <p>I have also been counseled on how to resist attempts to engage in sexual activities that are against my will.</p>
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I understand that I have the option of obtaining prescriptions for all of my medical supplies including birth control and having them filled at the pharmacy of my choice or receiving them here at the health center if available.

I have reviewed my medical and social history with ACAP Health Services staff and acknowledge that the information I have given is accurate and complete.

_____ Signature of Client	_____ Date
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I witness the fact that the client received the above mention information and said she/he read, understood it and had the opportunity to ask questions.

_____ Signature of Staff Witness	_____ Date
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____ Check here if client's guardian or relative is legally required to sign below		
_____ Signature of guardian/relative	_____ Relationship to client	_____ Date
I witness the fact that the client's legal guardian (or person consenting to her behalf) received the above mentioned information and said she read and understood it.		
_____ Signature of staff witness	_____ Date	