Contraceptive Implant Procedures
GP Referral Form

Sexual Health Quarters

Date _____

Client details

First name_____ Family name _____ Date of Birth _____
Address _____
_____ Phone number:_____

Section 1: referral for contraceptive implant insertion/changeover

☐ Requesting Contraceptive Implant insertion / changeover
(if referring for removal only, please skip down to section 2)

☐ Implanon insertion

☐ Contraceptive Implant removal and Implanon insertion

Type of current contraceptive Implant:
☐ Implanon
☐ Jadelle
☐ Other (please specify): _____

Is the current Contraceptive Implant easily palpable?
☐Yes ☐No (please specify): _____

History

Reason for considering Contraceptive Implant _____
_____

Any abnormal menstrual symptoms?
(intermenstrual bleeding, postcoital bleeding, breakthrough bleeding) ☐Yes* ☐No

*If **yes**, investigate and DON'T refer to SHQ. Follow guidelines:
Abnormal Vaginal Bleeding in Pre- and Peri-Menopausal Women, found at: tinyurl.com/3txn3uxs

SHQ will not insert a Contraceptive Implant unless abnormal vaginal bleeding has been fully investigated by a gynecologist, and we have received evidence of the letter and investigation results.

Usual Menstrual cycle _____
LMP _____
Current contraceptive method _____

Any other contraindications for Contraceptive Implant?
(including ischemic heart disease, history of stroke, current/past breast cancer, severe cirrhosis, hepatocellular adenoma / carcinoma)
☐No ☐Yes (please specify): _____

Does the client have any medical issues?

☐No ☐Yes (please specify): _____

Is the client on any medication?

☐No ☐Yes (please specify): _____

Discussion

Other contraceptive options discussed

☐Yes ☐No

Comment: _____

Efficacy discussed ☐Yes ☐No

Procedure explained ☐Yes ☐No

Possible risks and adverse effects discussed (changes to bleeding cycle, bruising/soreness/scaring at insertion site, acne, functional ovarian cysts, headaches, mood changes, breast tenderness, change in libido, weight gain) ☐Yes ☐No

Costs discussed. Please visit shq.org.au/clinic-costs ☐Yes ☐No

Client has been given information sheet and consent form to sign.

Please visit: tinyurl.com/2u3p9ejb ☐Yes ☐No

Plan

Pre-insertion contraception:

☐ Unexpired Intrauterine Device
☐ Unexpired Contraceptive Implant
☐ Abstinence from LMP or 3 weeks prior to insertion
☐ Combined Oral Contraceptive Pill
☐ Progesterone Only Pill
☐ Contraceptive injection
☐ Vaginal Ring
☐ Barrier methods

Please prescribe the Implanon and advise the client to present with the device to the appointment.

Please skip down to section 3

Section 2: referral for contraceptive implant removal

☐ Requesting Contraceptive Implant removal only
(if requiring removal and re-insertion, please complete section 1 above instead)

History

Type of Contraceptive Implant:

☐ Implanon
☐ Jadelle
☐ Other (please specify): _____

Is the current Contraceptive Implant easily palpable?
☐Yes ☐No (please specify): _____

Reason for requesting Contraceptive Implant removal:

☐ Due / overdue for removal
☐ Pregnancy planning
☐ Side effects/problems (please provide details on investigations/treatment options to date):
_____
_____
☐ Other (please specify): _____

Discussion

Choice of ongoing contraception: _____
☐ N/A (pregnancy planning or post-menopausal)

Procedure explained ☐Yes ☐No

Costs discussed. Please visit shq.org.au/clinic-costs ☐Yes ☐No

Client has been given consent form to sign.
Please visit: tinyurl.com/2u3p9ejb ☐Yes ☐No

Plan

Client has been advised to use alternate contraception for 7 days prior to removal appointment
☐Yes
☐No
☐N/A (pregnancy planning, post-menopausal, expired contraceptive implant)

Please complete section 3

Section 3: Client confirmation and referrer contact details

Doctor has covered all the above information with me (Client) ☐ Yes
Client name _____ Signature _____ Date _____

Contact

Please fax/email this referral and all results to SHQ on 9228 9010 | helpline@shq.org.au
Please ask the client to contact the Sexual Health Helpline (SHH) to make an appointment on 9227 6178 once all the results and the referral have been sent.

Doctors Contact

Please sign and provide your contact details to confirm all the information on this form has been discussed with the client. Alternatively, use a Drs stamp below:

Doctors name _____
Doctors signature _____
Address _____
_____
Phone _____
Email _____
Provider number _____

Drs stamp