PLANNED PARENTHOOD® OF SOUTHEASTERN VIRGINIA
403 Yale Drive, Hampton, VA 23666 (757)826-2079
515 Newtown Road, Virginia Beach, VA 23462 (757)499-7526

PLEASE PRINT LEGIBLY

URINE PREGNANCY TEST

☐ **(PLEASE CHECK) I have received a copy of the *Patient's Bill of Rights and Responsibilities* and *Patient Complaints* policy**

Last Name: **First Name:** **Middle Initial:**

Address: **Apt #** **City:** **State:** **Zip Code:**

Employer:	**Email address:** **(cannot be used for test results)**	
Home Phone #:	**Cell Phone #:**	**Work Phone #:**

Emergency Contact Name: **Phone Number:**

We are committed to maintaining your confidentiality. At times it is necessary for us to contact you, usually with the results of an abnormal test, through phone calls, email, text &/or mail (plain white envelope)

Please check the methods we can use to contact you? ❑Phone Call ❑Mail

Please provide a password to receive test results over the phone____________________

Date of Birth	**Sex** ❑ Female ❑ Transgender Pronoun you like: ❑ She ❑ Other ____ **Do you have a living will?** ❑ Yes ❑No	**Monthly Income** $	**Family Size Supported By Income**

How did you hear about us? ❑ AD (circle) Billboard Phonebook TV Radio ❑Newspaper/Magazine
❑ Other Planned Parenthood ❑ Doctor ❑Family ❑Friends ❑School ❑Online ❑Facebook

Race ❑ Caucasian ❑ American Indian/Alaskan ❑Multiracial
❑ African American ❑ Asian ❑ Pacific Islander ❑Other

Ethnicity
Hispanic? ❑Yes ❑ No

Highest Level Of Education Completed ❑ Middle School ❑ High School ❑Some College ❑Bachelors/Masters/PhD

MEDICAL SCREENING (COMPLETED BY CLIENT)

1st day of last menstrual period __________ **Was it normal?** ❑ Yes ❑ No If no, explain:______________________

Reason for Test ❑ Planned Pregnancy ❑ Contraceptive Failure ❑ No Regular Birth Control

Test Results You Hope To See ❑ Negative ❑ Positive ❑ Doesn't matter

	Yes	No	**Are you currently experiencing?**	Yes	No
Are you currently using birth control? If yes, what method? ____________________ For how long?			Spotting/Bleeding		
			Fever		
			Abdominal Pain		
			Vomiting		
Do you have a history of?	Yes	No		Yes	No
Abnormal Bleeding			Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?		
Ectopic Pregnancy					
Missed or Spontaneous Abortion (Miscarriage)			Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?		
Pelvic Infection					
Are you currently experiencing any signs or symptoms of pregnancy? If yes, explain:			Does your partner refuse to use a condom when you ask?		
			Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be?		
			Are you afraid of your partner?		

ASSESSMENT (COMPLETED BY CLINIC STAFF)

Gravida _____ Para_____ Live Births _____ Spontaneous Abortion _____ Elective Abortion_____ Living children ___

Urine high-sensitivity HCG Pregnancy Test Order/Result: ❑ Negative ❑Positive (EDC:_______EDD:________) ❑ Indefinite

Patient Education V=Verbal H=Handout	V	H		V	H		V	H
			CIIC EC			CIIC Pregnancy Tests		
	V	H	CIIC HOPE			STIs		
BCM Options			CIIC Contraceptive Implant			Prenatal Care		
CIIC Pill,Patch, Ring			CIIC IUC			Adoption		
CIIC DMPA			CIIC Barriers (condoms)			Abortion		
CIIC POPs			CIIC Essure			CI Sx of Early Pregnancy		

For **NEGATIVE** Results-
❑ Explained limitations of test (morning urine sample/time since last period)
❑ Advised re-test in 1-2 weeks
❑ Discussed blood PT
❑ Advised RTO if no menses for 3 consecutive months
❑**If Minor: Encouraged parental involvement**

Intake Staff Signature: **Date:**

Licensed Qualified Staff Signature: **Date**:

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REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

DATE ____________________________

Patient Label

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

Please note that Planned Parenthood Southeastern Virginia is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I will be told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood Southeastern Virginia *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Planned Parenthood Southeastern Virginia notice of health information privacy practices.

Signature of patient ____ Date _______________

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness ____ Date _______________

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting ____________________________________

Relationship to patient ____

Date _______________

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness ____

Date _______________