

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			
<input type="checkbox"/> (PLEASE CHECK) I have received a copy of the <i>Patient's Bill of Rights and Responsibilities and Patient Complaints policy</i>					
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? <input type="checkbox"/> Phone Call <input type="checkbox"/> Mail Please provide a password to receive test results over the phone					
Date of Birth		Sex <input type="checkbox"/> Female <input type="checkbox"/> Transgender Pronoun you like: <input type="checkbox"/> She <input type="checkbox"/> Other _____		Monthly Income \$	Family Size Supported By Income
		Do you have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No			
How did you hear about us? <input type="checkbox"/> AD (circle) <input type="checkbox"/> Billboard <input type="checkbox"/> Phonebook <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper/Magazine <input type="checkbox"/> Other Planned Parenthood <input type="checkbox"/> Doctor <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> School <input type="checkbox"/> Online <input type="checkbox"/> Facebook					
Race <input type="checkbox"/> Caucasian <input type="checkbox"/> African American		<input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander		<input type="checkbox"/> Multiracial <input type="checkbox"/> Other	Ethnicity Hispanic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Highest Level Of Education Completed <input type="checkbox"/> Middle School <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> Bachelors/Masters/PhD					
MEDICAL SCREENING (COMPLETED BY CLIENT)					
1 st day of last menstrual period _____ Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain: _____					
Reason for Test <input type="checkbox"/> Planned Pregnancy <input type="checkbox"/> Contraceptive Failure <input type="checkbox"/> No Regular Birth Control					
Test Results You Hope To See <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Doesn't matter					
		Yes	No	Are you currently experiencing?	
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				Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?	
Missed or Spontaneous Abortion (Miscarriage)				Does your partner refuse to use a condom when you ask?	
Pelvic Infection				Has your partner ever tried to force or pressure you to become pregnant when you didn't want to be?	
Are you currently experiencing any signs or symptoms of pregnancy? If yes, explain: _____				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: <input type="checkbox"/> Negative <input type="checkbox"/> Positive (EDC: _____ EDD: _____) <input type="checkbox"/> Indefinite					
Patient Education V=Verbal H=Handout		V	H	V	H
				For NEGATIVE Results-	
				<input type="checkbox"/> Explained limitations of test (morning urine sample/time since last period)	
				<input type="checkbox"/> Advised re-test in 1-2 weeks	
				<input type="checkbox"/> Discussed blood PT	
				<input type="checkbox"/> Advised RTO if no menses for 3 consecutive months	
				<input type="checkbox"/> 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 _____	