DOCUMENTATION FORM

To be completed by Pharmacist

Patient Name:	**Date of Birth:** _____/_____/_____	**Today's Date:** _____/_____/_____

SUBJECTIVE

OBJECTIVE

Blood Pressure Measurement(s): _____/_____ **mmHg** _____/_____ **mmHg**

Pregnancy Screen (can be reasonably certain a patient is not pregnant if no symptoms of pregnancy and meets any one of the following)

Has it been ≤ 7 days after the start of normal menses?	❒ Yes	❒ No
Has the patient NOT had sexual intercourse since the start of last normal menses?	❒ Yes	❒ No
Has the patient correctly and consistently been using a reliable method of contraception?	❒ Yes	❒ No
Has it been ≤ 7 days after spontaneous or induced abortion?	❒ Yes	❒ No
Is the patient within 4 weeks postpartum?	❒ Yes	❒ No
Is the patient fully or nearly fully breastfeeding (exclusively breastfeeding or vast majority (≥ 85%) of feeds are breastfeeds), amenorrheic, and < 6 months postpartum?	❒ Yes	❒ No

Health History

Other (e.g. pulse, weight)

ASSESSMENT

PLAN AND FOLLOW-UP

❒ Counseled on dosage, effectiveness, how to start method, when to use a back up method, how to take, potential side effects, safety, recommended preventative health screenings, condoms to prevent STDs.

Patient education handouts given:

Prescription Issued ❒ **Yes** ❒ **No**

Medication Name: ________________________________ **Dose:** ________________

Sig: ________________________________ **Number of Refills:** ____________

Medication Administered ❒ **Yes** ❒ **No**

Medication: ____________________ Site: __________ Lot#:: __________Exp Date: _____/_____/_____

❒ Patient referred for:

❒ Contraceptive Care	❒ Pap test/HPV test	❒ STD/HIV Screening
❒ Pregnancy Care	❒ Pelvic Exam	❒ Blood Pressure
❒ LARC evaluation/placement	❒ Breast Exam/Mammogram	❒ Diabetes
❒ Other:______________		

PCP Notified : ❒ Yes, PCP/practice:____________________ ❒ No PCP ❒ No, Patient declined

Notified by: ❒ phone ❒ fax ❒ email on _____/_____/_____

Pharmacist Name: ____________________________ **Pharmacist License Number:** ______________

Signature:____________________________________ **Date:** _____/_____/_____

BIRTH CONTROL **PHARMACIST**

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