Family Planning Service Form

Which Caregiver/Adult was involved (Client Name)?

_____

Date of Activity: _____/_____/_____

Per client request, information on this form is confidential: (Select one)
- Yes
- No

Provider (Staff or Medical providing services to client with highest level of training): (Select one)
- Physician
- PA/APRN/CNM
- Other
- Registered Nurse

SCREENING QUESTIONS

Are you pregnant? (Select one)
- Yes
- No
- N/A—Services for Male

Would you (and/or your partner) like to become pregnant in the next year? (Select one)
- Yes
- No
- Client is unsure
- Client is OK either way

Do you smoke? (Select one)
- Yes
- No

Do you drink alcohol or use other substances? (Select one)
- Yes
- No

Screenings Conducted (Select all that apply):
- Tobacco Use
- Alcohol Use
- Substance Use (legal or illegal)
- Mental/Behavioral Health
- Depression
- Intimate Partner Violence
- Human Trafficking
- Diabetes
- Hypertension

PROGRAM SERVICES

Visit type: (Select one)
- Initial Visit
- Periodic/Follow-up Visit

Program Services: (Select all that apply)
- Clinical Breast Exam
- Chlamydia Test
- Contraceptive Follow-up
- Counseling for Tobacco Use
- Counseling for Alcohol Use/Substance Use (legal or illegal)
- Counseling for Mental/Behavioral Health
- Counseling for Depression
- Counseling for Intimate Partner Violence
- Counseling for Human Trafficking
- Counseling for Diabetes
- Counseling for Hypertension
- Education
- Gonorrhea Test
- HIV Test
- Pap Test
- Pregnancy Test
- STD/STI Treatment
- Syphilis Test
- Other STD/STI Test
- Other Screening

Pap test Result: (Select one)
- Did not conduct Pap test
- Normal
- ASC or higher
- HSIL or higher
- Not conclusive

Clinical Breast Exam Result: (Select one)
- Did not conduct Clinical Breast Exam
- Normal
- Abnormal

Referral for further evaluation based on the Clinical Breast Exam: (Select one)
- N/A (select if a CBE was **NOT** performed during visit)
- Yes
- No

HIV Test Result: (Select one)
- Did not conduct HIV test
- Positive
- Negative

Other STD/STI Test Type:

_____

Specify Other Screening Type:

_____

Type of Contraceptive Method at end of visit: (Select one)

- Abstinence
- Cervical Cap
- Diaphragm
- FAM/LAM
- Female Condom
- Female Sterilization
- Hormonal Implant
- Hormonal Injection (1 mo.)
- Hormonal Injection (3 mos.)
- IUD/IUS
- Male Condom
- Male: rely on female method(s)
- Oral Contraceptive
- Patch
- Spermicide (Alone)
- Sponge
- Vasectomy
- Vaginal Ring
- Withdrawal or other method*****
- Unknown/Not Reported
- None

***Specify Other Contraceptive Method:**

_____

Reason for no contraceptive method: (Select one)

- Pregnant/Seeking Pregnancy
- Other Reasons

Specify Other Reason:

_____

Duration of Visit: (Minutes) _____
(Include number of minutes spent in direct contact with client by ALL service providers during the visit)

Are any referrals needed? (Select one)

- Yes (If yes, fill out the referral form)
- No