**VIRGINIA DEPARTMENT OF HEALTH**

***Informed Consent for Special Health Services and Procedures***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / / \_\_\_\_\_

**Health Department/Center Patient Name Birth Date Age**

I hereby authorize the Physicians, Nurses Practitioners, Nurses, and/or other medical care providers of the Virginia Department of Health to examine and/or treat me and/or my dependent, as named above, with the following services/procedures. I have been made aware of the risks and benefits associated with the procedure(s), and I have been given the opportunity to ask questions.

**Contraceptives Date Procedures Date**

Nexplanon Insertion \_\_\_\_\_\_\_\_\_\_  Endometrial Biopsy

Nexplanon Removal \_\_\_\_\_\_\_\_\_\_  Colposcopy – with or without Cervical

IUD Insertion (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ Biopsy and/or Endocervical Curettage

IUD Removal (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_  Other Biopsy – (*list site in Remarks*)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_  Cysts - Aspiration

Cysts – Incision or Drainage

Telemedicine

Remarks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This consent will remain in effect as long as I receive care from the Virginia Department of Health or until I withdraw it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship (if signature is not of Patient) Signature of Clinician Obtaining Consent**

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| --- | --- | --- | --- | --- |
| ***Reaffirmation of Information or Consent for Additional Special Health Services***  [This section is for periodic re-affirmations of original consent and for consenting to new or additional services/procedures added since initial consent.] By signing below, I agree that the information shown in this consent form is accurate as of the date I enter my signature*.* | | | | |
|  | **Signature of Patient/Guardian/Other** | **Date** | **Signature of Person Obtaining Consent** | **Date** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |
| **5** |  |  |  |  |
| **6** |  |  |  |  |