**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**

|  |
| --- |
| ***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** |  |  |  |  |