

**Procedure: Removal of sub-dermal Contraceptive Implant** (where consciousness is not impaired)

Patient's surname: ..... Patient's first names: .....

Date of Birth: ..... NHS Number: .....

Address: .....

**Statement of health professional** (to be filled in by health professional with appropriate knowledge of proposed procedure)

I have explained the procedure to the patient /parent. In particular, I have explained:

**Benefits:** .....

- Risks:**
- Bruising and infection
  - Risk of scar tissue
  - Failure to remove
  - Tingling
  - Numbness
  - Injury to nerves and blood vessels

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of those involved.

The following leaflet has been provided .....

Signed ..... Date: .....

Name (print): Dr H Cole / Dr C Allen Job Title: GP

**Statement of interpreter** (where appropriate)

I have interpreted the information above to the patient / parent to the best of my ability and in a way in which I believe they can understand.

Signed ..... Date .....

Name (print) .....

**Statement of patient / person with parental responsibility to the patient**

**I agree** to the procedure described above. **I understand** the procedure will / will not involve local anaesthesia. **I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

Signed ..... Date .....

Name (print) ..... Relationship to patient.....