

IUD SCREENING AND PLACEMENT

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Screening (By staff)

Possible complications and side effects reviewed, including:

- Possible ↑ bleeding (CuT) / cramping
- Irregular bleed / Amenorrhea (LNG-IUDs)
- Spontaneous expulsion of IUD
- Infection (first 3 weeks)
- Perforation

Lab tests and evaluation as indicated (Active cervicitis: Tx and defer placement x 2 weeks)

Pregnancy test (as indicated): Date: _____ Result: _____

Chlamydia / Gonorrhea (as indicated): Date: _____ Result: _____

Consent reviewed, signed LMP: _____

Manufacturer's package insert given Recent BCM: _____

Ibuprofen mg PO at time: _____ Last UPSIC: _____

Staff signature: _____ Date: _____

IUD Placement (Provider)

Exam: _____

Examination	Normal	Abnormal (if abnormal, specify)	
External genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Uterine position: _____
Vagina	<input type="checkbox"/>	<input type="checkbox"/>	Sound depth: _____ cm
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	String length: _____ cm
Uterus	<input type="checkbox"/>	<input type="checkbox"/>	
Adnexa	<input type="checkbox"/>	<input type="checkbox"/>	

Cervical block / prep: _____

IUD placed: ParaGard Liletta Mirena Skyla Kyleena Remove by date: _____

Follow Up Appointment (as needed): _____

Clinician Signature: _____ Date: _____

IUD Follow-Up Exam	Does the client have...?	YES	NO	YES	NO
Date: _____	Unusual vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Fever / chills	<input type="checkbox"/>
LMP: _____	Abnormal vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>
	Missed / light menses	<input type="checkbox"/>	<input type="checkbox"/>	Pain with intercourse	<input type="checkbox"/>

Examination:	Normal	Abnormal (if abnormal, specify)	
External genitalia	<input type="checkbox"/>	<input type="checkbox"/>	Complaints: _____
Vagina	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	String length: _____ cm
Uterus	<input type="checkbox"/>	<input type="checkbox"/>	Assessment: _____
Adnexa	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Management: _____

Clinician Signature: _____ Date: _____