

St Stephen's Surgery

Adelaide Street,
Redditch, Worcestershire B97 4AL

Tel: 01527 595600 Fax: 01527 69218
www.ststephenssurgery.co.uk

NAME: Full Name

DOB: Date of Birth

Name of procedure: Removal of Nexplanon

Statement of health professional (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy).

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

The intended benefits are:

- Removal of Contraceptive Method for Reasons:
 - Adverse or undesired effects
 - Wish to conceive
 - Following expiry date / No longer needed for contraception
 - Rapid return of fertility after removal

Serious or frequently occurring risks:

- Infection
- Bruising
- Risk of damaging blood vessels and nerves
- You will be left with a small scar
- Rarely difficult to locate so may need ultrasounded guidance.

Health Professionals Signature:..... Date.....

Name..... Job Title.....

Statement of the patient:

I agree to the procedure described above.

I understand that the procedure will involve local anaesthesia and that it is important to keep the site dry until it is healed.

Patients Signature..... Date.....

Name.....