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|-------------|
| Name: _____ |
| Date: _____ |
| DOB: _____ |

Pregnancy Test Visit Form

First day of last menstrual period: _____
Was it normal? Yes No If No, explain: _____

Have you already had a pregnancy test? Yes No
When? _____
Result? _____

Were/Are you using a method of birth control? Yes No
If Yes, what method? _____

If you are pregnant, are you interested in discussing your options today? Yes No

If your pregnancy test is negative, would you like to start on birth control? Yes No

Client Signature: _____ Date: _____

FOR STAFF USE ONLY:

Pregnancy Test CIIC Given: Yes No

Pregnancy Test Results: _____

POSTIVE RESULTS:

____ Options discussed

____ Patient wishes to parent:

____ Patient referred to insurance company for prenatal care.

____ Patient referred to low cost prenatal care.

____ Patient desires abortion:

____ Patient given information on abortion services at PPM.

____ Patient given appointment phone number for PPM abortion.

____ Patient referred off-site for abortion services.

____ Patient given adoption referral list.

NEGATIVE RESULTS:

____ Advised to repeat UCG at _____

____ Discussed possible reasons for a missed period.

____ Condoms offered

____ Discussed EC for future use.

____ Indication for EC today?

____ HOPE appointment done today.

____ HOPE appointment offered for a later date.

____ Advised to continue current method of birth control.

Notes: _____

Staff Signature: _____ Date: _____

Clinician Signature: _____ Date: _____