Family Planning Service Form

Which Caregiver/Adult was involved (Client Name)?

_____

Date of Activity: _____/_____/_____

Per client request, information on this form is confidential: (Select one)
- Yes
- No

Provider (Staff or Medical providing services to client with highest level of training): (Select one)
- Physician
- PA/APRN/CNM
- Other
- Registered Nurse

If "Physician" or "PA/APRN/CNM", please provide Attending physician National Provider Indicator (NPI) Number:

_____

Client's current method of contraception reported at beginning of visit: (Select all that apply)
- Combined oral contraceptive pills
- Progestin only contraceptive pills
- Male condom
- Female condom
- IUD Copper
- IUD unspecified
- IUD with Progestin
- Contraceptive patch
- Diaphragm or cervical cap
- Implantable rod
- Sponge
- Vaginal ring
- Emergency contraception
- Female sterilization
- Fertility awareness-based methods
- Injectables
- Lactational amenorrhea method
- Male relying on female method
- Spermicide
- Vasectomy
- Withdrawal
- Decline to answer
- None

Reason for no contraceptive method use: (Select all that apply)
- Abstinence
- Same sex partner
- Sterile for non-contraceptive reasons
- Seeking pregnancy
- Other

Specify other reason:

_____

SCREENING QUESTIONS

Screenings Conducted (Select all that apply):
- Tobacco Use
- Alcohol Use
- Substance Use (legal or illegal)
- Mental/Behavioral Health
- Depression
- Intimate Partner Violence
- Human Trafficking
- Diabetes
- Hypertension

Are you pregnant? (Select one)
- Yes
- No
- N/A—Services for infant, child or male

PROGRAM SERVICES

Visit type: (Select one)
- Initial Visit
- Periodic/Follow-up Visit

Program Services: (Select all that apply)
- Clinical Breast Exam
- Chlamydia Test
- Contraceptive Counseling
- Contraceptive Follow-up
- Counseling for Tobacco Use
- Counseling for Alcohol Use/Substance Use (legal or illegal)
- Counseling for Mental/Behavioral Health
- Counseling for Depression
- Counseling for Intimate Partner Violence
- Counseling for Human Trafficking
- Counseling for Diabetes
- Counseling for Hypertension
- Counseling to Achieve Pregnancy
- Education
- Gonorrhea Test
- HIV Test
- Pap Test
- Pregnancy Test

- STD/STI Treatment
- Syphilis Test
- Other STD/STI Test
- Other Screening

Other STD/STI Test Type:

_____

Specify Other Screening Type:

_____

Systolic blood pressure: _____

Diastolic blood pressure: _____

Body Height (metric): _____

Body Weight (metric): _____

Clinical Breast Exam Result: (Select one)
- Did not conduct Clinical Breast Exam
- Normal
- Abnormal

Referral for further evaluation based on the Clinical Breast Exam: (Select one)
- N/A (select if a CBE was **NOT** performed during visit)
- Yes
- No

Has the client had a Pap test performed in last 5 years? (Select one)
- Yes
- No

Pap test performed at this visit? (Select one)
- Yes
- No

If "Yes" to Pap test performed:
Pap Test Method – LOINC Code:

_____

Pap Test Result – Coded: (Select one)
- Atypical squamous cells, cannot exclude high-grade squamous intraepithelial lesion
- Atypical squamous cells of uncertain significance, probably malignant
- Low-grade squamous intraepithelial lesion
- High-grade squamous intraepithelial lesion
- Squamous cell carcinoma, no International Classification of Diseases for Oncology subtype
- Atypical glandular cells on cervical Papanicolaou smear
- Atypical glandular cells, favor neoplastic
- Adenocarcinoma in situ
- Negative for intraepithelial lesion or malignancy
- Specimen satisfactory for evaluation
- Specimen unsatisfactory for evaluation

HPV test performed at this visit? (Select one)
- Yes
- No

If "Yes" to HPV test performed:
HPV Test Method – LOINC Code:

_____

HPV Test Result – Coded: (Select one)
- Positive
- Detected
- Negative
- Not detected
- Equivocal
- Indeterminate

Chlamydia test performed at this visit?
- Yes
- No
- Chlamydia trachomatis and Neisseria gonorrhoeae combined test

If "Yes" or "Chlamydia trachomatis and Neisseria gonorrhoeae combined test":
Chlamydia Test Method – LOINC Code:

_____

Chlamydia Test Result – Coded: (Select one)
- Positive
- Detected
- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate
- Not applicable
- Quantitative lab

Neisseria gonorrhoeae test performed at this visit? (Select one)
- Yes
- No
- Chlamydia trachomatis and Neisseria gonorrhoeae combined test

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If "Yes" or "Chlamydia trachomatis and Neisseria gonorrhoeae combined test":
Neisseria gonorrhoeae Test Method – LOINC Code: _____

Neisseria gonorrhoeae Test Result – Coded: (Select one)
- Positive
- Detected
- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate

HIV Test performed at this visit? (Select one)
- Yes
- No

If "Yes" to HIV test performed:
HIV Test Method – LOINC Code:
_____

HIV Test Result – Coded: (Select one)
- Positive
- Detected
- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate
- Reactive
- Non-Reactive
- Not applicable
- Quantitative lab

Syphilis test performed at this visit? (Select one)
- Yes
- No

If "Yes" to Syphilis test performed:
Syphilis Test Method – LOINC Code:
_____

Syphilis Test Result – Coded: (Select one)
- Positive
- Detected
- Negative
- Not detected
- Inconclusive
- Equivocal
- Indeterminate
- Reactive
- Non-Reactive
- Not applicable
- Quantitative lab ([arb'U]/mL)
- Quantitative lab (Titer)

Type of Contraceptive Method at end of visit: (Select one)
- Abstinence
- Cervical Cap
- Diaphragm
- FAM/LAM
- Female Condom
- Female Sterilization
- Hormonal Implant
- Hormonal Injection (1 mo.)
- Hormonal Injection (3 mos.)
- IUD/IUS
- Male Condom
- Male: rely on female method(s)
- Oral Contraceptive
- Patch
- Spermicide (Alone)
- Sponge
- Vasectomy
- Vaginal Ring
- Withdrawal or other method*
- Unknown/Not Reported
- None

***Specify Other Contraceptive Method:**
_____

Reason for no contraceptive method: (Select one)
- Pregnant/Seeking Pregnancy
- Other Reasons

Specify Other Reason:
_____

If Type of Contraceptive Method was selected at end of visit, How was it provided? (Select one)
- Provided on site
- Referral
- Prescription

Duration of Visit: (Minutes) _____
(Include number of minutes spent in direct contact with client by ALL service providers during the visit)

Are any referrals needed? (Select one)
- Yes (If yes, fill out the referral form)
- No