Center For
WOMEN'S HEALTH
& WELLNESS

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Depo-Provera Consent

Patient Name: _____

Date Of Birth: _____/_____/_____

I have read the information sheet in its entirety and discussed its content with my clinician. My clinician has answered all my questions and has advised me of the risks and benefits associated with the use of DEPO PROVERA, with other forms of contraception, and with no contraception at all.
I am aware of the other methods of birth control I could use to prevent pregnancy.
I have considered all these factors and voluntarily choose to have the DEPO- PROVERA injections every 12 weeks, but not to exceed 2 years unless approved by a physician.
I realize it is my responsibility to make my 12 weeks contraceptive appointment.
I realize it is my responsibility to take 1500mg calcium daily as long as I am receiving the injection stated above.
I understand that I should use an additional contraceptive for two (2) weeks after my first injection.

You may purchase DEPO- PROVERA with a written prescription from your clinician. The prescription can be filled out at the Tulane Student Health Pharmacy or any pharmacy of choice. DEPO- PROVERA injections are given by scheduled appointment only.

Patient Signature: _____

Date: _____/_____/_____

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