Center For
WOMEN'S HEALTH
& WELLNESS

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IUD Consent

I have read the patient information booklet and have had my questions about the IUD _____ answered and I am fully aware of possible risks involved which include but are not limited to:

- Pregnancy- Intrauterine or Ectopic (pregnancy in fallopian tube).
- Pelvic infection, pelvic pain, infertility, or need for pelvic surgery.
- Expulsion (falling out of uterus).
- IUD becoming imbedded in uterus or perforating through the uterine wall into the abdomen.
- Increased cramping, bleeding, dizziness, or faintness while IUD being inserted.
- Spontaneous abortion

By signing this form, I am indicating that I have discussed any questions or concerns with my Doctors, and I have verbally told the Doctors that I understand the information provided.

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Signature: _____ Date of Service: _____/_____/_____

Doctor: _____ Doctor Signature: _____

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