

REQUEST FOR PRESCRIPTION FOR ORAL CONTRACEPTIVES

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Date: _____

Time: _____ a.m./p.m.

I hereby acknowledge that I have received from _____, MD, a booklet containing information on the use, effectiveness, and known hazards of oral contraceptives, including _____, and that I have been informed by _____, MD, of the possible serious side-effects of such said oral contraceptives, including but not limited to phlebitis, thromboembolism, breakthrough bleeding, and hepatic disease and informed of alternative methods of contraception. I further acknowledge that I understand such information and warnings.

I understand that such oral contraceptives are prescribed for the intended purpose of preventing future pregnancies, but no guarantees or assurances of the results of the use of such oral contraceptives have been given to anyone. I nevertheless request _____, MD, to prescribe for me, or for _____ the oral contraceptive _____.

Patient or person authorized to consent for patient

Witness

Date: _____