

# Consent for Intrauterine Device (IUD) Removal

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I am requesting the removal of an intrauterine device.

I have been informed and understand that the contraceptive effect stops immediately.

I understand that if I am in the middle of my menstrual cycle and have been sexually active during the week before removal, there is a risk of pregnancy.

- I have been informed of and understand the possible side-effects and complications of IUD removal:
  - ▶ There may be some cramping/pain or bleeding.
  - ▶ If the threads are no longer visible, or they break during the procedure, I may require a scan or need to be referred to another provider to have the IUD removed.
- I have been given the opportunity to ask questions.
- I give consent for the IUD removal.

Patient's name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- (Where applicable) I give consent for a health professional who is training in this skill to do the removal.

Patient's name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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- I have talked about the side-effects and complications of an IUD removal, and have explained that the contraceptive effect stops immediately.
  - I have given the patient the opportunity to ask questions.

Clinician's name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_