FAMILY PLANNING HOME VISIT

RECIPIENT'S NAME: _____ AGE: _____

MEDICAID NUMBER: _____

ADDRESS: _____

SERVICE: _____ DATE: _____

FAMILY PLANNING CONSENT

I, _____, voluntarily request and consent to receive family planning
(Recipient's Name)

services from _____
(Physician or Practice Name)

I understand that a brief history, including family, personal, medical, and contraceptive information will be obtained prior to the provision of home visit services and selection of a birth control method. I understand that I should receive a follow-up visit within six weeks for regular family planning services at the provider's office/clinic.

_____ _____
Recipient's Signature Date

The Recipient has voluntarily given consent for family planning services. No coercion or mental pressure was applied in obtaining the Recipient's signature.

_____ _____
Witness's Signature Date

_____
Title

FAMILY HISTORY (Code: F-Father, M-Mother, S-Sibling, GP-Grandparent, O-Other)

Heart disease		Diabetes		Mental retardation		Tuberculosis		Foster Care	
Stroke		Cancer		Mental illness		Birth defects		Blood disease	
Asthma		High BP		Alcohol/drug abuse		Other			

MEDICAL/SURGICAL/OB-GYN HISTORY (Code: O=Negative, +=Positive, Detail positive answers)

Diabetes		Epilepsy		Tobacco Use		Mental		Abortions	
Hypertension		Hepatitis		Phlebitis		GYN Surgery		Stillbirths	
Heart Disease		Tuberculosis		Asthma		Gravida		Medications	
Kidney Disease		Thyroid		Allergies		Para		Other	

Type: _____ Year: _____

Type._____ Year_____

Type._____ Year_____

Remarks: _____

_____

_____

_____