# IUD MEDICAL SUPERVISION FORM

Name of Doctor of Nurse Date

New Acceptor

A. Information

Was patient given full and accurate information on the IUD?

 Yes No

1. Told of possible bleeding \_\_\_ ­\_\_\_

2. Told of possible backaches \_\_\_ \_\_\_

3. Told of possible pregnancy \_\_\_ \_\_\_

4. Told of possible expulsion \_\_\_ \_\_\_

##### Contraindications Determined

 Yes No

 1. Large fibroids \_\_\_ \_\_\_

 2. Pelvic Inflammatory Disease \_\_\_ \_\_\_

 3. Carcinoma \_\_\_ \_\_\_

 4. Pregnancy \_\_\_ \_\_\_

 5.Recent menorrhagia or metrorrhagia \_\_\_ \_\_\_

C. Examination and Preparation

 Adequate Inadequate Comments

 1. Was a pelvic examination done \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

2. Was a sounding taken \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

3. Placement of speculum \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

4. Cleaning cervix \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

5. Loading inserter \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

6. Aseptic technique \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

7. Placement of tenaculum \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

D. Insertion

 Adequate Inadequate Comments

1. Traction with tenaculum \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

2. Placement of IUD in proper

 uterine plane \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

3. Withdrawal of plunge \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

4. Removal of speculum \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

E. Post insertion

 Yes No When

1. Was patient told to return? \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

2. Was patient warned of possible bleeding? \_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

3. Was patient instructed to check the strings? \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_

F. Return Visit

1. Why did the patient return?

 General Check up?

 Complication?

2. If complication, what was the complication?

3. What treatment was given? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

4. Was the patient's treatment adequate or inadequate?

5. Was the patient charged a fee? No **\_\_\_\_** Yes **\_\_\_\_\_** How much? **\_\_\_\_\_\_**

6. Was the IUD removed? Yes **\_\_\_\_\_** No **\_\_\_\_\_\_**