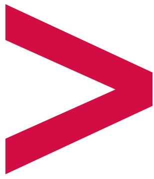

Emergency Contraception Screening/Assessment for Patients

(For use if EC is provided under a standing order, NOT if provided over-the-counter)

Name (First & Last): ______________________________ Date: ________________

Date of Birth: ____________________

Address: ____

City: ________________ State: ______ Zip: ____________ Phone: _____________

Please answer the following questions to help us understand what you need right now.

1. Women have many reasons for requesting Emergency Contraception. Please tell us your reason for asking for EC today. Check all that apply.

☐ Future need

☐ Unprotected sex or your birth control did not work within the last 5 days
What day? ______________

2. When was the start of your last menstrual period? ________________________________

3. Was this period normal in the length (number of days) and amount of bleeding?

☐ Yes ☐ No

4. Are you allergic to any medications?

☐ Yes ☐ No

If yes, what? ____

5. Would you like a referral for more information about:

☐ Birth control
☐ Pregnancy counseling & testing
☐ Primary care
☐ Sexual assault/rape crisis services
☐ STI/HIV counseling & testing
☐ Other:______________________________

For Pharmacist use ONLY

Pharmacist:________________________________ Date & time of assessment:________________________

Was EC provided? ☐ Yes ☐ No

If yes, what product?

☐ Plan B

☐ OCPs, Brand:________________________________

What information did you provide to the patient?

☐ Patient Instructions for Use ☐ Patient fact sheet

☐ Referral for:

☐ Birth control
☐ Pregnancy counseling & testing
☐ Primary care
☐ Sexual assault/rape crisis services
☐ STI/HIV counseling & testing
☐ Other:________________________

Additional Pharmacist Notes/Comments: