

VT Form B: Client Informed Consent and Referral

Client's Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth (Month / Day / Year): ____ / ____ / ____

I have been given the Emergency Contraception Key Facts and Instructions for Use and have had access to information about EC:

Client's signature _____ **Date** _____

Pharmacist's signature _____ **Date** _____

I understand that it may be useful to share this treatment information with my regular health care provider and I make the following decision:

No (Do not share)

Yes I request and authorize the release of this information to the following designated provider:

Name of Designated Provider _____

Provider's Address _____

For ASAP Referrals: Provider's Phone Number: _____

Provider's Fax Number: _____

Client's signature _____ **Date** _____

FOR PHARMACIST USE ONLY:

Client provided with:	Referral Made for?	Additional pharmacist notes/comments:
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Key Facts Sheet (Form C)

Contraception

Informed Consent (Form B - this sheet)

STI/HIV

EC Product

Pregnancy

Plan B™

Primary Care

Other

Sexual Assault State Hot Line 1-800-489-7273

Child Abuse Call DCF 1-800-649-5285

Date: ____ / ____ / ____

Time: ____ : ____ AM/PM (Circle One)

Pharmacist's Signature: _____ R.Ph./Pharm D

Pharmacist: 1) Keep original copy for your records. 2) Give a copy to the client. 3) If release is authorized, give a copy to the designated provider.