Contraceptive Counseling: *The Counseling Session*

modification date:	July 25, 2013
content:	Baseline Clinical Form Instructions

Overview

This set of instructions should be used to guide contraceptive counselors in completing the Baseline Clinical Form, which captures a patient's general medical and reproductive health history. If the contraceptive counselor is unsure of how to record any part of this form, he/she should leave it blank and refer to the clinician. This form can be modified to omit irrelevant questions or to include other information that may be important for your organization to capture. The questions from the Baseline Clinical Form are denoted by italics.

To insert your clinic/organization's name in the designated space on the Baseline Clinical Form, right click in the area and select "Edit Header" on the top of the page, and "Edit Footer" on the bottom of the page.

Introduction

Say the following to the patient: "I'm going to ask you some questions about your health history in order to further determine what birth control method may be appropriate for you. Please answer as honestly and openly as you can, and if you have any questions or comments feel free to interrupt me. Remember, the information that you provide is kept completely confidential and is not shared with anyone outside the clinic."

Note: Pregnancy test results and height, weight and blood pressure measurements will need to be obtained prior to presenting the patient's medical history to the clinician. It is up to each clinic to determine the best time during the clinic visit is best to obtain this information. This information was obtained by contraceptive counselors prior to starting the counseling session at the CHOICE project.

Patient Information

- Record patient's legal last name.
- Record patient's legal first name.
- Fill in today's date (MM/DD/YY) and time (24hr).
- *What is your date of birth?*
  - Record patient's date of birth (MM/DD/YY).
- *How old are you?*
  - Record patient's age (years).
- *How did you hear about our organization?*
  - Record response on the "referred by" line.
- *Who is your OB/GYN health care provider*?
  - Specifically, who she sees for OB/GYN care. Record patient's response on the line.
- *How many times have you been pregnant*?
  - Record the patient's gravidity in the space provided.
  - Gravidity represents the total number of times the patient has been pregnant regardless of whether she carried it to term.
- *How many times have you given birth*?
  - Record the patient's parity in the space provided.

- Pregnancies consisting of multiples, such as twins, count as one birth for this question; in other words, do not count the number of children that result from the birth for this question.
- Parity refers to any delivery after 20 weeks.

General Health Information

- Fill in height in feet/inches and weight in pounds.
  - These values are recorded on this form after you have actually obtained her height and weight with shoes off
  - These measurements should be rounded to the nearest whole number
- Record blood pressure (mm/Hg).
  - If blood pressure is 98/62, record 098/062 in the boxes to avoid confusion.
  - If blood pressure is taken more than once, record numbers for the last blood pressure taken or the most accurate. For example, if blood pressure is taken first by the automatic blood pressure machine and then manually, record the results from the manual blood pressure test.
  - The procedure for checking blood pressure will be as follows:
    - Patient will first have a BP taken electronically.
    - If BP is elevated (>139/89) it will be repeated manually. If the counselor is not trained to take a manual BP reading, a medical assistant, nurse, or clinician will need to assist.
    - If the manual pressure is normal, (< 140/90), this should be taken as the final measurement and the patient should NOT be considered to have elevated BP.
- *Do you smoke cigarettes?*
  - Mark yes or no on form with an "X"
    - **IF YES***: How many years have you smoked?*
      - Record response in space provided. Round to whole year.
    - *How many cigarettes do you smoke in a day or week?*
      - Pick day or week and record the appropriate response.
      - Special situation #1: If patient reports smoking half a pack per week, record 10 cigarettes per week, as there are 20 cigarettes in a pack.
      - Special situation #2: If patient reports smoking less than 1 cigarette per week then record 1 per week.
- Record the patient's pregnancy test by marking "negative" or "positive" with an "X."
  - **IF POSITIVE:** follow your clinic protocol to inform the patient of a positive pregnancy test.

Contraception Information

- *What method of contraception are you currently using*?
  - Record answer in the correct space
    - If patient has made a conscious decision to be abstinent, record "abstinence"
    - If patient is currently pregnant, record "currently pregnant"
    - If patient has never had intercourse, record, "abstinence – never had intercourse" and skip to the question, *" What method are you interested in today"*

        - If patient is having vaginal sex without using any method including condoms or withdrawal record "nothing" and skip to the question, "*How long have you been using this method"*
- *Have you been using this method consistently?*
    - Mark yes or no with an "X"
- *What is the last date (MM/DD/YY) that you last used (current contraception)?*
    - Record response in the correct space
- *How long have you been using (current contraception)?*
    - Record length in years, months and days.
    - If patient reports using method 1.5 years, record "1" year and "6" months and "0" days.
- *What method are you interested in today?*
    - Record patient's desired method(s) by marking an "X" next to the method(s). If she is not sure, you can leave this section blank.
- *Do you remember when the first day of your last period was*?
    - Record the first day of her last period (MM/DD/YY)
    - If patient can only remember the month and year, record month and year and leave the day blank.
    - If patient's period was too long ago to remember, mark the corresponding box with "X"
    - If patient has never had a period, mark the corresponding box with an "X"

Gynecological History

This set of questions refers to a patient's menstrual cycle when she is not using a hormonal birth control method. Say to the patient: "For the next set of questions, think of a time when you were not using a birth control method with hormones, such as the pills or birth control shot."

- *Are your periods regular or irregular*?
    - Mark the box that matches the patient's response with an "X"
- *How often would you say your periods come?*
    - This is from the beginning of one period to the beginning of the next period. Write in range.
    - If the patient indicates her periods come every 30 days, record "30" to "30"
    - If the patient indicates her periods come every 25 to 33 days, record "25" to "33"
    - If the patient indicates that this is too irregular to tell, mark the corresponding box with an "X"
- *Are your periods painful?*
    - Mark yes or no box with an "X"
- *On average, would you consider your periods light, moderate, or heavy*?
    - Mark the correct box with "X"
    - Only one response should be recorded.
    - As a guide:
        - Light= less than 11 pads/tampons throughout the course of a period
        - Moderate= 11-20 pads/tampons throughout the course of a period
        - Heavy= more than 20 pads/tampons throughout the course of a period
- *How long do your periods last?*
    - Write in range.
    - If the patient indicates periods last 7 days, record "7 to 7" days
    - If the patient indicates periods last 4 to 5 days, record "4" to "5" days

- If the patient indicates that this is too irregular to tell, mark the corresponding box with an "X"

- *When was the last time you had vaginal sex?*
  - Record the date in the space provided (MM/DD/YY).
  - If the patient does not remember the exact date, record month and year when possible and leave date blank.
  - If the patient has not had intercourse, leave this blank.
- *Did you use a condom from start to finish?*
  - If yes, mark the corresponding box with an "X"
  - If patient has not had sex or does not remember the last time she had sex, leave this blank.
- *What year did you have your last pap smear?*
  - Write in year (YYYY) if patient knows
  - Mark the unknown box with an "X" if patient does not remember
  - Mark the never had pap box with an "X" if patient has never had a pap smear
- **If the patient has had a pap**: *Do you remember if it was normal or not?*
  - Record normal or abnormal with an "X"
  - If the patient doesn't remember mark the Unknown box with an "X"
  - Leave blank if patient has never had a pap
- *Have you ever had an abnormal pap?*
  - **IF YES**: *what was the follow up treatment?*
  - Record the year and type of procedure in the Surgical History section of the Baseline Clinical Form. Procedures could include a LEEP, Colposcopy, or Biopsy. It is also possible that the patient received no followup treatment.

If Pregnant (skip this section if patient is not currently pregnant)

- *How many weeks pregnant are you?*
  - Record answer in whole weeks.
- *When is your due date or end (i.e. abortion) date?*
  - Record answer *(*MM/DD/YYYY). Circle whether you recorded due or end date.

Obstetrical History

- *How many total times have you been pregnant?*
  - This includes term births (≥37 weeks), premature births (< 37 weeks), miscarriages (< 20 weeks), stillbirths (≥ 20 weeks), abortions and ectopic pregnancies.
  - Record the patient's total number of pregnancies in the space provided.
  - The number in this box should equal the number entered in Gravidity Box on Page 1.
- Present each category of pregnancy classifications to the patient
- *Record the total of each type of pregnancy followed by the month/year for each outcome*
  - If the response is none, record a zero in the space provided
  - If the patient reports a term birth or premature birth, record the type of delivery. A normal vaginal delivery (NVD) is recorded next to the month and year of the outcome (i.e., 12/2011 NVD). A c-section (C/S) is recorded next to the month and year of the outcome and (i.e., 11/2009 C/S) and under the Surgical History section.
  - ***If the patient reports a Miscarriage(s) less than 20 weeks****?*

        - Record any relevant follow up procedures in the Surgical History section, i.e. D&C
    - **IF YES to elective abortion(s):**
        - Record the type of procedure—surgical abortion (SAB) or medicated abortion (MAB) next to the month/year of the procedure, (i.e. 9/2009 SAB)

- Important General Notes for the Obstetrical History Section
    - If month is unknown for any pregnancy, just record the year.
    - If the pregnancy resulted in a miscarriage, abortion, or ectopic enter the date of the event. Even if the pregnancy included multiples, only record 1 event and 1 date (e.g., the date of the first miscarriage).
    - If the patient had twins it is possible for this to result in one live birth and one stillbirth. Also, events should only fit into one category, i.e. a premature birth should be counted as a premature birth only (not a premature birth and a term birth).
    - If the patient is going to have an abortion but has not had it yet, DO NOT include it on the abortion line or record a scheduled date. You should have completed this information in the IF PREGNANT section above and included the "Estimated End" Date. The same is true for a currently pregnant woman who is going to deliver post-36 weeks. You should record that information in the IF PREGNANT section above.

Infection History

- *Now I'm going to ask you if you have ever been diagnosed by a clinician with a sexually transmitted infection. Have you ever been diagnosed with*…….say gonorrhea, chlamydia, trich, etc.
    - **IF YES to any infection,** record month/year they were diagnosed and if they took medication for treatment.
    - If the patient is unsure as to whether or not they have been diagnosed with an infection, mark the unknown box with an "X"
    - If month is unknown just record year. If year is unknown record "UNK" in the month/year field.
    - If they have been diagnosed with an infection more than once, multiple months/years should be recorded.

Allergies

- *Are you allergic to any medicines, or to latex, copper or shellfish?*
    - **IF YES to allergies**: mark yes with an "X"
        - Document the allergy and specify the type of reaction.
        - EXAMPLE: Penicillin-rash.
    - **IF NO to allergies:** mark "No known Allergies" with an "X"

Current Medications

- *Are you currently on any prescribed medication (including inhalers) or taking any over-the-counter medications on a regular basis*?
    - Fill in medication, dose, and how many times per day
    - EXAMPLE: amoxicillin/500mg/2x a day

- If you need more space, you should continue the list on the backside of the document and insert a note

Surgical History

- *Have you ever had any surgeries to your reproductive system before?*
  - **IF YES to surgeries,** record the type of surgery or procedure and year it was performed (YYYY).
  - You may have already captured and recorded these surgeries through earlier questions
  - EXAMPLE: C-section. LEEP, Colposcopy, Biopsy, Surgical Abortion.
  - If the patient has had more than 1 of the same procedure, this should be recorded on two separate lines.

Medical History

- *Now I'm going to ask you about any medical conditions you might have been diagnosed with throughout your life. Have you ever been diagnosed with Cancer? HIV? Hypertension? (continue through list and ask about each condition)*
  - If patient reports never having the condition,
    - Mark the "N" box with an "X"
  - If patient reports having had a condition,
    - Mark the "Y" box with an "X"
    - Record the year(s) (YYYY) in the space provided.
    - Example: If patient has been diagnosed with cancer in both 1984 and 2004 record 1984; 2004.
    - Determine whether she is currently experiencing the condition or it has been resolved:
      - You will mark only one of the 4 boxes ("Y", "N", "Resolved", "NA")
      - First determine whether the patient is currently experiencing the condition.
        - If yes, ask whether she is being treated and mark "N" or "Y" accordingly.
        - If she is no longer experiencing the condition, ask whether the condition has been resolved. If it has been resolved mark an "X" in the "Resolved" box.
        - On the rare occasion where the 3 responses regarding current treatment or resolved do not apply mark "NA."
- When asking about Aura with migraines ask the patient if the spots have visual changes, have numbness in their hands or face or have unusual sensations before their headaches.

Additional Comments

- Write in anything you feel is important for the clinician to know or anything you feel should be documented. If there are no additional comments, mark N/A box with an "X."

If Verbal Signature Obtained

- This section should only be completed if the counselor presents to the clinician over the phone.

Signatures

- Print your name, then sign and date (MM/DD/YY) in the signature section.
- Have this available for a clinician to review and prescribe an appropriate form of contraception.
    - The clinician will sign the form. If a method is approved he/ she will mark yes
    - If a method is not approved, the clinician will mark no and use the space provided to explain why.