Sunshine Pediatrics of Florida
18934 N Dale Mabry Hwy,
Lutz, FL 33548

Name: _____
Date: _____ ____ ____
DOB: _____

Pregnancy Test Visit Form

First day of last menstrual period:_____
Was it normal? ☐ Yes ☐ No If No, explain:_____

Have you already had a pregnancy test? ☐ Yes ☐ No
When? _____
Result? _____

Were/Are you using a method of birth control? ☐ Yes ☐ No
If Yes, what method? _____

If you are pregnant, are you interested in discussing your options today? ☐ Yes ☐ No

If your pregnancy test is negative, would you like to start on birth control? ☐ Yes ☐ No

Client Signature: _____ **Date:**_____

FOR STAFF USE ONLY:

Pregnancy Test CIIC Given: Yes ☐ No ☐
Pregnancy Test Results: _____

POSTIVE RESULTS:

____ Options discussed
____ Patient wishes to parent:
  ____ Patient referred to insurance company for prenatal care.
  ____ Patient referred to low cost prenatal care.
____ Patient desires abortion:
  ____ Patient given information on abortion services at PPM.
  ____ Patient given appointment phone number for PPM abortion.
  ____ Patient referred off-site for abortion services.
____ Patient given adoption referral list.

NEGATIVE RESULTS:

____ Advised to repeat UCG at _____
____ Discussed possible reasons for a missed period.
____ Condoms offered
____ Discussed EC for future use.
____ Indication for EC today?
____ HOPE appointment done today.
____ HOPE appointment offered for a later date.
____ Advised to continue current method of birth control.

Notes: _____
_____

Staff Signature: _____ Date:_____
Clinician Signature: _____ Date:_____