

ABCD Family Planning

WHAT IS A FAMILY PLANNING VISIT?

A family planning visit is one in which a client of reproductive age—of any gender or sexual orientation—receives face-to-face services related to preventing unintended pregnancies or achieving planned pregnancies that result in healthy birth outcomes. Pregnancy intention must be assessed during the visit to determine the need for family planning services.

Family planning services include:

- Counseling and education on reproductive and sexual health
- Contraceptive services:
 - client-centered counseling on contraceptive method choices
 - shared decision-making approach to contraceptive choice
 - assessment of medical eligibility for specific contraceptive use
 - prescription for or on-site dispensing of contraceptive methods
 - contraceptive method management
- Pregnancy testing and options counseling
- Services to assist with achieving pregnancy
- Preconception health services
- Basic infertility evaluation and counseling/education
- STD and HIV counseling/education, prevention, testing, treatment
- Anticipatory guidance for adolescents on sexual development, sexuality, reproductive coercion, and decision-making
- Related preventive health services including breast, cervical, and testicular cancer screening

A Family Planning Encounter Record data form (FPER) should be submitted for all family planning visits as defined above, **regardless of the reimbursement source for that visit.**

When an FPER is submitted for a family planning visit, the medical record **must provide documentation of family planning services, including counseling/education**, as defined above. Medical record documentation must correspond with what is coded on the FPER.

Note that the following are **not** considered family planning clients for the purposes of data collection through this project:

1. A person who is post-menopausal
2. A person who had a permanent contraception (sterilization) procedure prior to their first visit

Provision and documentation of family planning services is expected to be in accordance with the evidence-based recommendations in the following documents (and updates) and in ABCD

- *Family Planning protocols*
- *Providing Quality Family Planning Services, Office of Population Affairs and CDC, 2014*
- *U.S. Selected Practice Recommendations for Contraceptive Use, CDC, 2016*
- *U.S. Medical Eligibility Criteria for Contraceptive Use, CDC, 2016*
- *STD Treatment Guidelines, CDC, 2015*

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Title X Services

Medical Services Covered Under Title X

PROCEDURES	
<ul style="list-style-type: none"> - Colposcopy (with or without biopsy) - LEEP (Loop Electrosurgical Excision Procedure) * - Cry Cautery * - Nexplanon Implantation * - Nexplanon Removal - Depo Injection 	<ul style="list-style-type: none"> - Female Sterilization * - IUD Insertion * - IUD Removal - Vasectomy * - Venipuncture (Blood draw) - Wart Treatment
LABORATORY AND OFFICE MEDICAL SERVICES	
<ul style="list-style-type: none"> - Anemia Screening - Blood Pressure - Blood Type and RH - Breast Exam - CBC - CBE Referral - Chlamydia Test - Cholesterol - Creatinine Blood Work - Emergency Contraception - GC - Glucose - Hemoglobin / Hematocrit - Hep B and Hep C Tests - Hep B Vaccine 	<ul style="list-style-type: none"> - Herpes / HSV Culture - Herpes Serum Antibody - HIV Test - HPV Test - Lipid Panel - Pap Smear - Pelvic Exam - Pregnancy Test - Rectal Exam - RPR - Rubella Antibody - Thyroid Stimulating - Urinalysis - Urine Culture - Urine Sensitivities - Wet Prep / Mount
BIRTH CONTROL	
<ul style="list-style-type: none"> - Depo Provera Injection - Birth Control Pills - Vaginal Ring 	<ul style="list-style-type: none"> - Emergency Contraception - Other Birth Control Options
SEXUALLY TRANSMITTED INFECTIONS Also called STDs	
<ul style="list-style-type: none"> - Education 	<ul style="list-style-type: none"> - Testing - Treatment
FREE & CONFIDENTIAL SERVICES FOR TEENS (& ADULTS) OF ALL GENDERS AND ORIENTATIONS	
<ul style="list-style-type: none"> - Birth Control - STI / STD Testing & Treatment - Unwanted Pregnancy Prevention 	<ul style="list-style-type: none"> - Family Planning Counseling - Risk Assessment - Other / ETC.
QUESTIONS/CONCERNS	
<ul style="list-style-type: none"> - The Family Planner Counselor at HSNHC 	

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Informed Consent Family Planning Services

Name: _____

Date of Birth: _____

Medical Record Number: _____

Delivery Site: _____

I voluntarily request family planning services. No one is forcing me to do this.

I was told about the physical exams and lab tests I may need related to family planning services.

I understand that all my personal health information will be kept confidential and will be used only by the health care providers involved in my care, unless I give my permission in writing or it is required or allowed by law. For example, some infectious diseases must be reported to the state department of public health.

I understand that I have a right to get a copy of all my medical records.

I understand that it is my responsibility to provide correct personal health information so that the health care providers can provide the care that is right for me.

I understand that I can get family planning services even if I cannot pay for these services.

I understand that I do not have to accept family planning services in order to get any other service at this health center.

I received instructions about how to contact the health center if I have questions or problems, or in an emergency.

I understand that the family planning services I am receiving may be funded in part by Action for Boston Community Development, Inc. (ABCD). I give ABCD permission to review my family planning record if needed to be sure the services are high quality. I understand that my name or other personal information will not be used by ABCD except for billing purposes.

I gave a phone number (confidential if necessary) where I can be reached in case of an emergency.

In addition, if I am under 18 years old:

I discussed whether I want to involve a family member in my decision to receive family planning services. I understand that I may ask for and receive family planning services without the permission or notification of a parent, other family member, or guardian.

I understand that information about my family planning visit may be shared without my permission if I am or may be abused or neglected, if I might harm myself or someone else, or if my life is in danger.

Signature of Client _____ Date _____

Signature and Title of Provider _____ Date _____

ABCD Family Planning Services
Harvard Street Neighborhood Health Center

Instructions: Please provide the following information and answer the questions below by circling your response. Answers are used by your Family Planning Counselor, Nurse, or Healthcare Provider (Doctor/Nurse Practitioner) to assess your family planning needs. You may circle more than one answer if it applies. Put "N/A" if a question does not apply to you.

Name: _____ Sex: _____

Today's Date: _____ Date of Birth: _____ Last Period: _____

Telephone #: _____ Any Concerns? _____

1. Which of the following do you identify as?
(a) Heterosexual/Straight (b) Homosexual (c) Bisexual (d) Questioning (e) Pansexual
(f) Other: (Please Explain) _____
2. At what age did you first become sexually active? _____
3. Are you currently sexually active?
(a) Yes (b) No
4. Your sexual partner(s) is/are:
(a) Male (b) Female (c) Male & Female (d) Transgender
5. How many partners have you had throughout your life? _____
6. How many partners do you have right now? _____
7. Do you have a partner that forces you to have sex?
(a) Yes (b) No
8. What type of sexual activity do you engage in?
(a) Vaginal (b) Oral (c) Anal (d) Other/Unknown
9. Have you ever exchanged sex for housing, food, money, etc.?
(a) Yes (b) No
10. How often do you use condoms?
(a) Never (b) 10% of the time (c) 25% of the time (d) 50% of the time (e) 75% of the time (f) 100% of the time
11. Have you had a sexually transmitted disease/infection in the past?
(a) Yes — Which? _____ (b) No
12. Would you like condoms today?
(a) Yes (b) No (c) Yes, but I can't (d) Maybe
13. Do you have children?
(a) Yes — How many? _____
(b) No — Do you want children? _____
14. Do you want a child within the next year?
(a) Yes (b) No (c) Maybe
15. Are you interested in birth control?
(a) Yes (b) No
16. Have you been on birth control in the past?
(a) Yes — Which? _____ (b) No

Evaluated By: _____

Interpreter (if applicable): _____