# 5.2A ADVERSE EVENT FORM

**Date of Visit:** (MM/DD/YEAR) __ __ /__ __ / __ __ __ __ **Clinic ID #:** _____ **Provider ID #:** _____

**Contraceptive Method** _____ **(if IUD, specify type** _____ **)**

**Reason for visit:** ☐Routine visit ☐Charge follow-up ☐High-volume site ☐Low-volume site ☐Clinic request ☐Adverse event follow-up ☐Inventory/reordering concern ☐Other_____

**Severe Adverse Event (select all that apply):**

☐ **IUD perforation**

How was the perforated IUD removed? (select all that apply) ☐Removed through the vagina ☐Laparoscopy ☐Hysteroscopy ☐Laparotomy ☐Other (describe below)

Were there other complications from the perforated IUD? (select all that apply)

☐None ☐Perforated bowel ☐Perforated bladder ☐Hemorrhage ☐Hysterectomy ☐Other (describe below)

**Hospitalization related to Z-CAN provided contraception**

**Diagnosis of Pelvic Inflammatory Disease (PID) in an IUD user** ▶ ○IUD NOT removed ○IUD removed

**Venous thromboembolism (deep vein thrombosis, pulmonary embolism)**

**Ectopic pregnancy (at Return Visit)** ▶ Had patient stopped contraception to achieve pregnancy? ☐Yes ☐No

**Please provide a brief description of the Severe Adverse Event with additional details not captured above:**

_____

_____

**Adverse Event, including device event (select all that apply):**

☐ **IUD expulsion** ▶ ○Partial (within cervical canal) Complete (IUD out of uterus and cervix)

☐ **Failed IUD insertion** ▶ ○device NOT contaminated device contaminated (▶ go to Product Documentation)

☐ **Skin infection around implant insertion site** ▶ ○Implant NOT removed Implant removed

☐ **Deep implant/Need for alternative measures for implant removal**

☐ **Pregnancy (at Return Visit)** ▶ Had patient stopped contraception to achieve pregnancy? ☐Yes ☐No

☐ **Broken implant**

☐ **Product Documentation (Record product contaminated or product used that patient never left clinic with)**

Type_____ Lot #_____ Exp. Date_____

☐ **Other** (describe below)

**Please provide a brief description of the Adverse Event (or device event) with additional details not captured above:**

_____

_____

**Was the patient seen at an outside location for management of this adverse event?** ○Yes ○No

If Yes ▶ Where? ○ER ○Hospital ○Another Z-CAN Provider (please specify below ○Other (please specify below)

_____

**Was the patient referred to another physician for this adverse event?** ○Yes ○No

If Yes ▶ Who? ○Assigned Consultant* ○Another Z-CAN Provider (please specify below)

_____

* Reminder: Obtain authorization from the assigned consultant prior to referring patient.

**Did the patient leave clinic today with a contraceptive method?** *(remember to fill out Initial or Return Visit Form)*

○ Yes ▶ please indicate method _____

○ No ▶ please indicate method _____

Do not include any personally identifiable patient information on this form (e.g. patient name, medical record number, phone number, e-mail address, mailing address, or date of birth)

Physician Initials:_____ and License #:_____

Please submit to the Z-CAN Program within 24 hours • **For Severe Adverse Events, call the administrative doctor within 24 hours**