(See DD Form 2005 for Privacy Act Statement)

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
DEPO-PROVERA ADMINISTRATION RECORD	

LAST PAP: DATE: _____ RESULTS: _____

PROVIDER ORDER:

-The patient's record has been reviewed and the patient has been counseled on the risk/benefit of this form of contraception.
-Give DEPO-PROVERA 150mg IM now and repeat every 12 weeks for a total of 4 injections.
-The patient attended the contraception class or was individually counseled on _____

PROVIDER SIGNATURE/DATE: _____

PATIENT CONSENT:

I have received written information about the action and side-effects of Depo-Provera and consent to its administration. I have been informed of the clinic policies regarding administration and refilling of this medication. I have received a copy of these policies.

PATIENT SIGNATURE/DATE:_____

1. DATE: _____ NURSE: _____ HCG (date/result):_____
LMP:_____ VITALS: BP_____ P _____
INJECTION SITE: _____ TIME ADMINISTERED: _____
COMPLICATIONS:_____
PATIENT COMPLAINT OF SIDE EFFECTS:_____
NEXT INJECTION DATE: _____

2. DATE: _____ NURSE: _____ HCG (date/result):_____
LMP:_____ VITALS: BP_____ P _____
INJECTION SITE: _____ TIME ADMINISTERED: _____
COMPLICATIONS:_____
PATIENT COMPLAINT OF SIDE EFFECTS:_____
NEXT INJECTION DATE: _____

3. DATE: _____ NURSE: _____ HCG (date/result):_____
LMP:_____ VITALS: BP_____ P _____
INJECTION SITE: _____ TIME ADMINISTERED: _____
COMPLICATIONS:_____
PATIENT COMPLAINT OF SIDE EFFECTS:_____
NEXT INJECTION DATE: _____

4. DATE: _____ NURSE: _____ HCG (date/result):_____
LMP:_____ VITALS: BP_____ P _____
INJECTION SITE: _____ TIME ADMINISTERED: _____
COMPLICATIONS:_____
PATIENT COMPLAINT OF SIDE EFFECTS:_____
NEXT INJECTION DATE: _____

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT