[Clinic Information]

REFERRAL REQUEST – IUD/IUS PLACEMENT

Patient Information [Addressograph/Sticker]

Name:
Date of Birth:
HCN:
Phone Number:
Address:

Referring HCP [Stamp]

Name:
Billing Number:
Fax:

Dear Doctor:
Please see this woman for IUD/IUS Placement for:

- ◯ Contraception
  - ◯ Nulliparous
  - ◯ Parous
- ◯ Menstrual Management [LNG IUS 52mg]
  - ◯ Please do Endometrial Biopsy if Indicated/Possible

- ◯ Rx already Provided
  Name of Device: _____
- ◯ Please advise as to preferred IUS/IUD to prescribe prior to visit
  RESPONSE: _____

Sincerely,

[HCP Name, Billing Number]

RESPONSE TO REFERRAL REQUEST – IUD/IUS PLACEMENT

Referring HCP [Stamp]

Name:
Billing Number:
Fax:

Re: _____
Date of Appointment: _____

Dear Doctor:
Thank you for referring the above named patient for IUS/IUD Placement. If the patient meets the following criteria, please provide prescription for a device to allow for same-day insertion.

- ◯ Able to tolerate pelvic examination/speculum examination, or willing to attempt first pelvic examination.
- ◯ No known uterine cavity abnormalities (routine pre-placement U/S not required)
- ◯ No history of PID or STI, OR History of STI/PID with documented treatment
- ◯ No history of recent molar pregnancy or puerperal sepsis
- ◯ No history of untreated high-grade cervical dysplasia or cervical cancer
- ◯ No unexplained abnormal vaginal bleeding

If unsure as to which device to prescribe:

- ◯ If menstrual management desired (e.g. heavy menses), prescribe LNG IUS 20 (52mg total)
- ◯ If nulliparous, consider LNG IUS 8 (13.5mg), LNG IUS 12 (19.5mg) or smaller-framed Copper IUD
- ◯ If patient complains of heavy or painful menses, IUS preferred over IUD
- ◯ Other recommendation: _____

Please suggest to patient, if no contraindication exists, to self-administer 400mg ibuprofen 1 hour prior to appointment. Do NOT fast for appointment. Do NOT prescribe misoprostol for cervical ripening.

Sincerely,

[HCP Name]