



miOttawa Department of Public Health

Not everyone is able to get their contraceptives by mail. Please read this first:

- Before each order, you must call to speak to a nurse.** The nurse will review your chart to make sure you are up to date on your medical exams, be sure you are tolerating your method well, determine how many refills you are able to order, where to mail your order, and other details. **Complete this page before calling.** Call the Holland office no matter where you usually go for your exams and contraceptive supplies. (Holland: 616-396-5266)
- Please order pills one month before you need them so that you can be sure that you receive them on time.
- If you fail to call first, your contraceptives will not be mailed and you will have a lapse in protection.
- PLEASE GIVE US A RELIABLE DAYTIME PHONE NUMBER.** If your re-supply form indicates a problem, we will probably not mail out the pills immediately without contacting you for more information.

Name: _____ Date: _____ Birthdate: _____

Mailing Address: _____ Phone: _____

City: _____ State: _____ ZIP: _____

Who is your Primary Care Provider? _____

What birth control method are you currently using? _____

Do you have any concerns to discuss with the nurse? Yes No

Date your last period started: _____ was it a normal period? Yes No

Could you be pregnant now? (frequently missed pills since last period) Yes No

Any pregnancies since your last visit with us? Yes No

Do you have allergies? Yes {list: _____} No

Are you a smoker? Yes No

Current medications: _____

Have you sought medical attention since your last visit? Yes No Reason: _____

The following questions are being asked so the nurse can better serve you based upon your particular circumstances:

Are you planning a pregnancy within the next 12 months? Yes No

Have you been with a new sexual partner since your last visit with us? Yes No

Have you or your partner traveled outside of the U.S. in the past year? Yes No

Are you or your partner planning travel outside of the U.S. in the next year? Yes No

PLEASE CHECK IF YOU ARE HAVING ANY OF THE FOLLOWING SINCE YOUR LAST EXAM:

- | | | | |
|-------------------------------------|--|------------------------------|--|
| 1. Frequent or severe headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Missed periods | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Severe chest/arm pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Bleeding between periods | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Difficulty breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Continual breast pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Swelling/pain in thigh/lower leg | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Severe abdominal pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Visual disturbances | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Weight change (>10 lbs.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Dizziness/fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Severe mood changes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Breast lump | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Other: _____ | |

Please explain any item checked 1-14: _____

Please read and sign below:

I request you send my contraceptives by mail. I will call the clinic or seek emergency care if any adverse symptoms or complications develop. These include, but are not limited to: pain in the chest, abdomen or arms; shortness of breath; unusual swelling or pain in the legs; severe headache; severe depression; blurred or double vision; yellowing of the skin.

YOUR SIGNATURE _____

(PLEASE TURN PAGE OVER)



miOttawa Department of Public Health

Before you may complete your order, you must call to speak to a nurse. Call the Holland office no matter where you usually go for your exams and contraceptive supplies. (Holland: 616-396-5266)

When you call, the nurse will tell you the quantities and fees for your contraceptives.

The maximum number of cycles available _____

Number of cycles requested _____

Cost per cycle _____

Cost of postage _____

TOTAL AMOUNT ENCLOSED (Number of cycles requested x Cost per cycle + Cost of postage and handling) _____

PLEASE BE ADVISED – PRICES SUBJECT TO CHANGE

Method of Payment:

- Check (payable to OCHD)
- VISA
- MasterCard
- Discover



Cardholder's Name: _____

Credit Card #: _____ Expiration Date: _____ CVV2# (3 digits): _____

Signature: _____

Upon receipt of your signed updated contraceptive re-supply form, we will process your order within 10 business days. Your order will be mailed or available for pick up if requested. If we are unable to fill your contraceptive request we will contact you via phone or mail. **Please, complete and send both pages of the form with your payment.** There is a \$15 fee for returned checks.

Mail the form to this address
 Ottawa County Department of Public Health
 12251 James Street Suite 500
 Holland, MI 49424 616-396-5266
 Fax 616-393-5659

DO NOT WRITE IN THIS BOX – FOR OFFICE USE ONLY

Staff Notes:

CHN Signature: _____ Date: _____ Pap follow-up: _____ AE due: _____