A. INITIAL VISIT

1. Initial history

   a. Relevant family history to include breast or uterine cancer, history of myocardial infarct, stroke, or thromboembolitic disorder before age 50, diabetes or other chronic or serious disorder, such as hypertension.

   b. Gynecologic history, including age of menarche, date of last normal menstrual period, history of dysmenorrhea, hypermenorrhea, oligomenorrhea, polymenorrhea, intermenstrual bleeding, post-coital bleeding, dyspareunia, previous history of pelvic infection, sexually transmitted infections, or vaginal discharge, date of last Pap test and any abnormal Pap tests and follow up.

   c. Obstetric history covering gravidity, parity, pregnancy outcome, i.e., number of abortions (spontaneous or induced), ectopic pregnancies, premature deaths, living children, breastfeeding status**,** and intervals between pregnancies. Specific complications of pregnancies should be recorded.

   d. Medical and surgical history - special emphasis on systemic review:

      1) Cardiovascular history, including peripartum cardiomyopathy
      2) Thromboembolic disease
      3) Hypertension (essential or malignant)
      4) Vascular or migraine headaches with pertinent neurological aura
      5) Rheumatic disease such as systemic lupus erythematosus (SLE)
      6) Neurologic/visual disturbances
      7) Metabolic history
         a) Diabetes, prediabetes, or gestational diabetes
         b) Hepatic disease
         c) Hyperlipidemia
         d) Thyroid disorders
         e) Gall bladder disease
         f) Bariatric surgery
         g) Inflammatory bowel disease
      8) Cancer (potential or confirmed) history
         a) Diagnosed or suspected breast cancer
         b) Diagnosed or suspected reproductive **tract** cancer
      9) Neurologic history
         a) Depression
         b) Epilepsy
      10) Hematologic history
         a) Hemoglobinopathies (e.g., Sickle cell trait or disease, thalassemia)
         b) Blood dyscrasias

11) Genito-urinary history
    a) Renal disease
    b) UTI
12) Previous contraceptive use and any problems with method.
13) Client's plans for any future pregnancies and when.
14) Social history including:
    a) Sexual history including partner history of:
        (1) injectable drug use
        (2) multiple partners
        (3) risk history for STIs and HIV
        (4) bisexuality
    b) History of physical**/**sexual abuse
    c) History of substance use/abuse
    d) History of smoking/tobacco use
14) Relevant socio-economic data.
15) Immunization for rubella, mumps, German measles (MMR), tetanus, pertussis, varicella, hepatitis B, Human Papilloma Virus, and annual flu vaccine.
16) DES history if born prior to 1970.
17) Nutritional history.
18) Allergies.
19) Current medications.

2. Client education

During the initial visit, all women **and men, as appropriate**, receiving family planning services must be provided information on the following, either verbally or in writing, when appropriate. Presentation of client education should be appropriate for client's age, knowledge, language, and socio-cultural background.

a. Brochure of family planning services is included in packet distributed to all initial clients. Staff answers any questions that the client poses either verbally or on history sheet/client assessment checklist.

b. Purpose and sequence of clinic procedure

Staff explains to client what will happen from the time of arrival to the time of leaving, including waiting time, lab tests, and medical exams. Results of routine tests (blood pressure, blood, and urine) are explained by designated staff. Questions are encouraged and answered by staff.

c. Basic female and male reproductive anatomy and physiology.

Reproductive Anatomy: Designated staff discusses basic anatomy and physiology in reference to birth control methods and answers questions indicated on the history form. Practitioner gives more detailed information during exams. Male and female reproductive anatomy and physiology diagrams are included in the Family Planning Program brochure.

Pelvic exam and Pap test procedures are explained.

d. Breast self-exam. - **Breast self-examination (BSE) is an option for women starting in their 20s. Women should be told about the benefits and limitations of BSE. Women should report any breast changes to their health professional right away.** (American Cancer Society Guidelines for Breast Cancer Screening: Last Revised: **10/04/2011**) **The BSE technique should be explained to clients.**

e. Methods of contraception

Specific factors concerning any method's safety (potential side effects or complications), effectiveness, acceptability to client and partner, correct usage, and how to discontinue use must be explained to client.

1) Temporary

a) Abstinence

b) Natural family planning methods

c) Spermicides: jelly, foam, suppository, film, sponge

d) Barrier: Diaphragm, male and female condom

e) FDA approved hormonal contraceptives, including hormonal implants

f) Intrauterine Device/System (IUD/IUS)

g) Emergency contraception

2) Permanent:

Male and female sterilization.

f. Rubella immunity: Importance of and how to achieve.

g. Importance of yearly flu vaccine**.**

h. Diethylstilbestrol (DES): use by client's mother (prior to 1970); implications for client

i. HIV risk assessment/AIDS education

All clients receive information about HIV and about behaviors that are high-risk for HIV infection. Referrals are available for counseling and testing sites as needed. (See HIV/AIDS prevention/risk reduction policy.)

j. STI counseling and education

k. Client rights and responsibilities

l. Emergency resources

m. Nutrition information from the history form should be discussed and questions answered. The importance of folic acid intake should be discussed/handouts given to all clients. Depo Provera/medroxyprogesterone acetate (DMPA) users must be counseled about increasing calcium intake and about the black box warning issued by Pfizer. Weight loss education/counseling if BMI $\geq$ 25.

n. Information about the vaccine for Human Papilloma Virus (HPV) for women and men 13 – 26 years old.

3. Initial female physical examination

The following are guidelines for the periodic health examination. Guidelines should never be a substitute for sound clinical judgment. References used in preparing these guidelines include:

1. American College of Obstetrics and Gynecology (ACOG) **Well-Woman Visit, Committee Opinion No. 534, August 2012;** 2. ACOG The Initial Reproductive Health Visit**,** Committee Opinion 460, August 2010; 3. ACOG Cervical Cytology Screening, Practice Bulletin No. 109, December 2009**;** 4. American Cancer Society (ACS), Recommendations for early breast cancer detection in women without breast symptoms (Last revision **10/4/2011).; ACOG Breast Cancer Screening, Practice Bulletin No. 122, August 2011; ACOG Well-Woman Care: Assessments & Recommendations, 3-29-2012.**

a. General overall appearance – All clients

b. Height, weight, and Body Mass Index (BMI) – All clients

c. Blood pressure – All clients

d. Thyroid – ACOG recommends starting at age 19

e. Clinical Breast Exam – ACOG recommends starting at age **20**

f. Heart – There is no recommendation for or against auscultation of the heart

g. Lungs – There is no recommendation for or against auscultation of the lungs

h. Abdomen – ACOG recommends starting at age 19

i. Extremities for varicosities and signs of phlebitis – There is no recommendation for or against examining extremities

j. Pelvic examination (including visualization and inspection of external genitalia, vagina, and cervix, and bimanual exam) – ACOG recommends starting at age 21, unless indicated by medical history at age <21.

k. Rectal examination, as indicated by medical history or findings on pelvic exam

4. Laboratory testing

a. The following procedures are to be done, according to the screening guidelines outlined in the Pap Test Screening and Follow-up protocol and the Laboratory protocol, unless written results from another facility are available:

1) Pap test, as per **American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP) and the American Society for Clinical Pathology (ASCP)** guidelines

Repeat according to Pap Test Screening and Follow up protocol

2) Chlamydia screening for all female clients <25 years

Must be done under the following circumstances:

a) All women <25 years of age, unless client declines (please document why)

b) Prior to (within 60 days and including a GC test) or at the time of IUD insertion

c) Symptomatic of cervicitis or pelvic infection (should include GC test)

d) When a client requests such screening

e) Contact to STI

Must be offered to the following:

a) Positive Chlamydia test in the past 12 months without a subsequent negative test.

b) Multiple sexual (≥2) partners or a new sexual partner(s) in the last 60 days

c) Women with a history of gonorrhea/PID in the previous year (should include GC test)

d) Anyone being treated for any other STI

b. Other laboratory tests, as indicated:

1) Pregnancy test

2) Microscopic examination of wet mounts or spun urines

3) HIV testing or referral for HIV testing

4) Rubella screening

5) Glucose screening for women with history of gestational diabetes.

6) Serology test for syphilis:

Must be done or a referral made if following conditions exist:

a) Client who reports having been exposed to, or suspects she may be infected with syphilis.

b) Client with previous positive serologic test for syphilis with incomplete or unknown treatment (do Syphilis testing).

c) Client with undiagnosed genital lesion, suspicious rashes, or other physical signs consistent with syphilis.

d) Client request.

e) Client with a positive HIV or gonorrhea test.

f) Depending on other risk factors, clients with condyloma, herpes, or Chlamydia should be offered a serology test for syphilis.

7) Focal Occult Blood Test (FOBT) (e.g. Hemocult) if $\geq$ 50 years old.

5. Provision of contraceptive methods

a. Abstinence.

b. Natural family planning.

c. Foam, creams, jellies, suppositories, sponges, film.

d. Barrier: Diaphragm, male and female condoms.

e. Hormonal contraceptives, including hormonal implant.

f. Intrauterine Device/System (IUD/IUS)

g. Emergency contraception.

h. Counseling for permanent methods: Male and female sterilization

6. Post-examination interview

a. Following the physical examination (done as indicated), the client should have an interview with an appropriately trained member of the health team. The interviewer should be able to answer the client's questions. The following should be covered during the interview:

1) Interpretation of clinical findings including history, physical examination (as appropriate) and laboratory results. If the client has an infection, the practitioner provides verbal information and appropriate brochure with explanation of infection and

treatment procedures. Current handouts or pamphlets on vaginitis, cervicitis, condylomata, herpes, Pelvic Inflammatory Disease (PID), Chlamydia, and other sexually transmitted infections should be available upon request or as indicated by client interest.

2) Answer questions about the contraceptive method or any part of the procedure up to that point.

3) Provide oral and written information on the following:

a) Directions for the chosen method of contraception and/or appropriate therapeutics

b) Name of the type of pill, diaphragm, or IUD used; removal date for IUD or etonorgestrol contraceptive implant

c) Potential side effects and complications for the method used, and what the client should do if any occur

d) How to discontinue prescription methods of contraception

b. Give written information of the following:

1) Office hours and telephone number

2) Reinforcement of emergency care and side effect information

3) Telephone number and location where emergency services can be obtained

c. Special counseling, as indicated, regarding:

1) Future planned pregnancies (see Preconception Counseling information on page 10 of this section)

2) Management of current pregnancy

3) Sterilization

4) Other individual problems or concerns (e.g., genetic, **infertility**, nutritional, sexual, **domestic violence, abuse)**

5) Substance use and abuse

a) For resources on screening for and referring clients for substance use and abuse see SBIRT Colorado, (Screening, Brief Intervention and Referral to Treatment) http://www.improvinghealthcolorado.org/index.php and Health Team Works http://www.healthteamworks.org/guidelines/sbirt.html

b) Each clinic site should have a list of substance abuse referral sites for clients.

6) All new adolescent clients are screened for social support and offered appropriate counseling referrals. Parental involvement is encouraged. Information about sexual coercion is also addressed with all new adolescent clients. Particular emphasis is placed on STI risk reduction strategies. Abstinence is addressed as a method of unplanned pregnancy prevention and as a STI risk reduction strategy. If a relevant history of sexual or physical abuse is reported by a client under the age of 18 yrs., this must, by law, be referred to Social Services or law enforcement. (See Section 1.10 - Adolescent Services of the Nursing Manual) Fewer requirements for the physical exam for adolescents <21 years will allow more time to be spent on adolescent counseling.

d. Nutrition education

1) Nutrition needs relative to birth control methods are discussed as appropriate. Nutrition protocols are available to help with counseling.

2) RN/NP should discuss nutrition as relevant to medical problems (obesity, anemia, anorexia-bulimia) and offer appropriate referrals for additional counseling/treatment.

e. Inform the client about the return visit schedule

1) Intake staff and practitioner discuss with the client the importance of periodic check-ups, how to obtain additional supplies, how to contact the clinic in between appointments, and what to do in case of a medical emergency.

2) Educate client about importance of follow-up.

a) Make appropriate referrals for any needed medical service not provided through the clinic. (See Section 1.5 - Referral and Follow-Up of the Nursing Manual).

b) Client education is documented in the chart.

B. REVISIT

1. PRN, if the lab tests indicate necessity (positive GC, abnormal Pap test, positive Chlamydia, etc.) or for subsequent boosters of HPV vaccine.
2. Oral contraceptive/contraceptive patch/contraceptive vaginal ring clients: 3 months after initial visit for all first-time hormonal contraceptive users; subsequently annually, unless client's risk status indicates more frequent evaluations. Established pill clients who change pill brand do not need a 3 month pill check. The next time the client comes in or calls, she should be questioned about how she is doing on the new brand.
3. DMPA (Depo-Provera or Depo subQ Provera 104) clients: every 11 - 13 weeks for re-injection.
4. IUD clients: Within 3 months of insertion; then annually.
5. Diaphragm clients: Within 2-4 weeks of fitting, to check fit; then at least every 2 years
6. Etonorgestrol contraceptive implant (Implanon) clients: PRN for signs of infection at insertion site, then annually;
7. As needed for any client experiencing contraceptive side effects or problems, or requiring additional information or supplies.
8. Content of revisit:

a. Update the chart in any area where changes have occurred, including changes in personal and family histories.

b. Laboratory tests as indicated by method or client history (e.g., GC if client indicates exposure; Hematocrit if IUD client indicates excessive bleeding)

c. Evaluation of any problem previously identified that may be unresolved.

d. Physical exam, as indicated by method:

1) Oral contraceptive/contraceptive patch/contraceptive vaginal ring clients:

a) Weight, if client wishes

b) Blood pressure.

2) Implanon clients:

a) Weight, if client wishes

b) Blood pressure

c) Insertion site, if indicated

3) Depo-Provera clients:

a) Weight, if client wishes

b) Blood pressure at first reinjection, then annually

4) IUD clients (2-3 months post insertion):

a) Visualization of cervix with string check

b) Bi-manual examination

5) Diaphragm clients:

Pelvic examination to assure proper placement and fit within one month of fitting.

e. Discussion with the client about any problems that may relate to the chosen method.

f. Specific information to be evaluated, by method (See specific method protocol):

g. Treatment, referral or change of method as required.

h. Education, as required.

1) Infection check: Provide information regarding cause, treatment, and involvement of partner.

2) Method Problem: After clinician has determined seriousness of problem, clinician or other staff should educate regarding alternative choices of birth control as indicated. Risks and side effects of given method shall be reviewed, as well as emergency procedures, to ensure client understanding.

3) Pregnancy Test: Client shall fill out request form, which is reviewed by appropriate staff. Counseling and referral shall be offered regarding options, including prenatal care, adoption, and termination for positive test results, and infertility or use of method counseling for negative test results, as appropriate.

4) Other: At any visit staff should assess client's needs for information, education, and counseling.

C. ANNUAL VISIT

(Or every 24 months services as indicated by client method and risk factors)

1. Update of initial history/family history. (Review history and problem list for unresolved problems. Complete medical and personal history must be redone every three years.).
2. Indicated laboratory tests (e.g., Pap test as per protocol).
3. Physical exam as indicated by method and current ACOG guidelines.
4. Education and counseling, as indicated.

All clients receiving family planning services will have their level of understanding assessed regarding:

a. Chosen method of birth control - accurate understanding of method and awareness of emergency contraception.

b. Breast Self-Exam, if client wishes, and HIV information, as appropriate.

c. Nutrition, including information on folic acid and calcium intake.

d. Reproductive anatomy and physiology.

e. Preconception counseling, as indicated.

f. Rationale for/results of lab tests.

g. Warning signs and emergency procedures.

h. Any informational brochures provided.

5. Education is documented in client record.

D. PROBLEM VISITS

At the time of the problem visit, there should be: (See appropriate protocol for indicated data collection, exam, treatment, and client education.)

1. Appropriate update of the chart.
   a. Evaluation of pre-existing problems or need for follow-up.
   b. History of new problems, if indicated.
2. Examination of the problem area and other areas, as indicated.
3. Performance of appropriate laboratory tests.
4. Change of contraceptive method, if indicated.
5. Referral for problem if unable to be resolved at this agency. (See Section 1.5 - Referral and Follow-Up of the Nursing Manual)
6. Education
   a. All clients shall receive information and education that ensures a thorough understanding of the findings of the visit. *Please refer to “8.h” under Content of Revisit on page 8.
   b. Education and counseling received is documented in client record, as are referral forms and pregnancy request forms.

E. SUPPLY ONLY VISIT

All clients shall receive the contraceptive selected at previous visit, have the opportunity to express concerns, and schedule a revisit if desired.

1. Staff will ensure that proper contraceptive prescription and education are on file in the client's record.
2. Client will be encouraged to express problems or concerns.
3. If necessary, client will speak with appropriate staff member for additional education/counseling. (This visit may then be coded as a revisit).
4. Staff should remind client of the next visit and reinforce importance and knowledge of emergency procedures.
5. Client visit will be documented as supply visit unless there is a face to face visit with a provider (thus coded as a revisit and not a supply only visit). If there is a face to face encounter, then there will be documentation of education given, if indicated. Contraceptives dispensed should be documented specifically, e.g., by type of pill, in all places required to comply with the Pharmacy Board and standard pharmacy practices.

F. PRECONCEPTION COUNSELING

Emphasize the importance to family planning clients on establishing a reproductive life plan. Provide preconception counseling as a part of family planning services, as appropriate**.** Clients contemplating pregnancy within the next year should be given the opportunity for special counseling prior to discontinuing their method, with the objective of improving the outcome of a

planned pregnancy. The following should be discussed:

1. History - an updated health history may be taken from the client, to include:
   a. Medical history, including rubella immune status, heart disease, hypertension, anemias or blood disorders, liver disease, diabetes, epilepsy.
   b. Reproductive history, including DES exposure, genital herpes, or previous pregnancy problems, risk status for HIV or Hepatitis B.
   c. Medication history
   d. Social and occupational history, including use of tobacco, alcohol, or other substances, domestic violence.
   e. Nutritional history, including the addition of 0.4 mg of folic acid/day, as recommended by the CDC in its MMWR, September 11, 1992; Vol. 41; No. RR-14
   f. Family history, including anemias or blood disorders, diabetes, or birth defects.
2. Physical exam
3. Lab tests as indicated
4. General education
   a. The need for early and continuing care during pregnancy, with referral to prenatal care providers, if requested
   b. The importance of good nutrition, including the addition of 0.4 mg of folic acid supplemented per day to decrease the risks of neural tube defects. **The importance of being a healthy weight before and during pregnancy.**
   c. Warnings regarding the use of tobacco, alcohol, and drugs during the preconception period as well as during pregnancy
   d. Assessment of potential high risk factors, including genetic risks, with referrals as indicated
   e. Counseling regarding HIV testing. The standard is for all pregnant women to be tested, regardless of risk status (Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant women in Health Care Settings, MMWR September 22, 2006/55 (RR14); 1-17). There are benefits to women and men of knowing their HIV status before a pregnancy.
   f. Assessment of psychosocial risk factors, including lack of support system or domestic violence/sexual assault.
   g. The importance of being up to date on immunizations prior to pregnancy.
5. Recommendations for Stopping Birth Control Methods
   a. Oral contraceptive/contraceptive patch/contraceptive vaginal ring
      1) There is no evidence to recommend that a period of time elapse between the cessation of hormonal contraceptive use and initiation of a planned pregnancy.
      2) Client may be advised to return for evaluation if menstrual periods do not resume six to eight weeks after cessation of these hormonal contraceptives.
   b. IUD

      No special recommendations
   c. Depo-Provera

Since ovulation may take as long as 9-12 months to return, it is advisable to have the client plan to stop the injections up to a year before she wishes to become pregnant, and to use another method of birth control until conception is desired.

d. Implanon

No special recommendations

G. MALE SERVICES

Title X requires documentation of a thorough medical history for male clients.

1. The medical data on the man's record for initial and follow-up visits shall include the following:
   a. Sexual history (as appropriate)
      1) Maternal use of DES through 1970
      2) Sexual preference
      3) Review of recent sexual activity
         a) Time since last sexual exposure
         b) Number of/new partners in the past 60 days
         c) Specific exposure sites (i.e., urethral, rectal)
         d) Any symptoms of STIs
         e) Illness or evidence of STIs in recent partners
      4) History of/risk for sexually transmitted infections, including hepatitis B and HIV
      5) Knowledge of how to do/importance of Testicular Self Exam (TSE). Because regular TSE have not been studied enough to show they reduce the death rate from testicular cancer, the ACS does not have a recommendation on regular TSE for all men. Each man should decide for themselves whether they will do a monthly TSE, so information about doing TSE should be provided to all men. (American Cancer Society, Testicular Cancer, last revised **5-4-2012)**
      6) Sexual dysfunction
   b. Contraceptive history (as appropriate)
      1) Methods used
      2) Problems/satisfaction with methods
      3) Methods requested today
   c. Number of children. Client's plans for future children
   d. Family history, general medical history (to include urological conditions), and review of systems

      To include immunization history for rubella, mumps, German measles (MMR), tetanus, pertussis, varicella, hepatitis B, hepatitis A, Human Papilloma Virus, and annual flu vaccine.

      To include depression**,** substance use/abuse, physical abuse, etc.
   e. Medication history
      1) Allergies to specific medications

2) Current medications being taken

3) History of antibiotic use in the previous two weeks

f. Reason for visit

1) Problem description

2) Symptoms

2. A physical examination must be offered initially, and at subsequent visits as appropriate. The routine physical exam could include:

a. Height, weight, and BMI

b. Blood pressure

c. Thyroid, heart, lung, extremities, breasts, abdomen, genital (more detail in f - k), prostate and rectal as indicated

d. Inspection of oral mucosa, if indicated

e. Inspection of skin for rashes and lesions

f. Inspection of pubic hair for lice and nits

g. Inspection of penis, including urethral meatus, retraction of foreskin, and expression of any discharge from the urethra.

h. Inspection of scrotum including anterior and posterior scrotal walls

i. Palpation of scrotal contents

j. Palpation of inguinal area for lymphadenopathy

k. Inspection of perianal area, if indicated

l. Further examination as indicated by history or laboratory findings.

3. Laboratory tests

a. Tests for gonorrhea/Chlamydia from urethra (using urine-based test), the rectum and/or oral pharynx should be done under the following circumstances (contact your lab for specifics on obtaining rectal or pharyngeal specimens):

1) History and/or findings of urethral or rectal discharge and/or dysuria

2) History of recent contact with Gonorrhea/Chlamydia/PID

3) Client requests a test for Gonorrhea, Chlamydia, or any other STI

4) Client is being treated for any other STI

5) Known multiple sexual partners or a change in sexual partners in the last 60 days (should be offered)

6) History of GC/NSU (non-specific urethritis) in the previous year

b. A serologic test for syphilis (RPR)

Please refer to the information on syphilis in Section 2.11 - STI Testing and Treatment of the Nursing Manual.

c. Test for HIV infection

Men with known risk factors for HIV infection should be advised as to testing availability. (See Section 1.13 - HIV/AIDS of the Nursing Manual)

d. FOBT (e.g. Hemocult) if ≥50 years old

4. Contraceptive education and counseling

   a. Men requesting a temporary method of birth control should receive the same education and counseling specific to that method as outlined in the methods protocols.

   b. Men requesting vasectomy should receive the education and counseling outlined in the sterilization policy. Give referrals for vasectomies, including No Scalpel Vasectomy (NSV) if available.

5. Nutritional counseling

   a. RN/NP should discuss nutrition as relevant to medical problems (e.g. obesity) and offer appropriate referrals for additional counseling/treatment.

H. Incorporation of ACOG's Primary and Preventative Care: Periodic Assessment Guidelines in to STI screening and treatment care

1. Colorado Family Planning Program clinic providers have incorporated ACOG's Primary and Preventative Care: Periodic Assessment, Committee Opinion No. 483, April 2011 in to practice. A pelvic examination (including visualization and inspection of external genitalia, vagina, and cervix, and bimanual exam) is not recommended for women until age 21, unless indicated by medical history. Female clients also are seen in the clinic for "express visits" or delayed exams in which the women are provided contraceptive counseling and a method of contraception without the provision of an exam. Asymptomatic male clients are also provided an opportunity for an express visit for contraceptive counseling and STI screening. Clients are asked to return to the clinic at a later date for a comprehensive history and an exam as indicated by the client's age or health history. Clinics have the capability of providing genital Chlamydia and gonorrhea screening for asymptomatic clients without the necessity of performing an exam with the use of urine based or vaginal self collected swabs for women and urine based testing for men.

2. Providing Chlamydia and Gonorrhea screening to asymptomatic clients without requiring an exam helps reduce barriers to screening. Colorado Family Planning clinic sites have adopted the practice of treating asymptomatic clients who have had screening Chlamydia or gonorrhea testing without an exam and a positive test without performing an exam prior to treatment.

3. Clients who have received Chlamydia and gonorrhea test screening without the performance of an exam and who have a positive Chlamydia or gonorrhea test must be questioned regarding complaints or reports of STI symptoms and the possibility of pregnancy before treatment is provided. A physical exam should be provided to clients who report STI symptoms. An exam is particularly important to rule out complications of Chlamydia and gonorrhea infections such as pelvic inflammatory disease (PID). Symptoms may include recent pelvic pain, pain with intercourse, or unusual discharge or bleeding.

4. Clients who have a positive Chlamydia or gonorrhea tests, who received a screening Chlamydia or gonorrhea test without an exam being performed and continue to be asymptomatic for STIs may be provided treatment without an exam being performed prior to treatment. Follow the CDPHE STI Testing and Treatment protocol.

5. Clients' partners should be treated as outlined in the CDPHE STI Testing and Treatment protocol.

6. **Clients should be counseled regarding STI prevention.**

7. **Clients should be counseled regarding the signs and symptoms of STIs and told to return to the clinic if any develop.**

8. **A repeat Chlamydia or gonorrhea test should be offered 3 months after treatment to rule out re-infection. Centers for Disease Control and Prevention. Sexually Transmitted Disease Treatment Guidelines, 2010. MMWR 2010; 59 (No. RR 12): pages 46, 52.**

I. CLIENTS INVOLVED IN RESEARCH PROJECTS

All programs considering clinical or sociological research must adhere to the legal requirements governing human subjects research (45 CFR Part 46). There must be informed consent of the client and approval of research by a properly constituted committee of the grantee institution. Copies of the federal regulations are available from the CDPHE Family Planning Program or by going to: http://www.gpoaccess.gov/cfr/index.htm

Programs must advise the CDPHE Family Planning Program in writing of research projects involving Title X clients or resources. The CDPHE Family Planning Program must then forward the request to the regional Health and Human Services office and the Office of Population Affairs.

(Program Guidelines 5.5, p.6)

SUMMARY OF SERVICE REQUIREMENTS

A. INITIAL VISIT

1. Education (group or individual)
2. Financial information
3. Complete medical history
4. Weight, height, and BMI
5. Blood pressure
6. Pap test, if indicated by screening guidelines
7. Chlamydia screening according to screening criteria
8. Fecal occult blood screening for men (should be offered) and women (must be offered) age 50 or over
9. Physical examination, as indicated
10. Post-exam interview
11. Supplies as needed
12. Return appointment recommendation or made

B. ANNUAL VISIT

1. Update database, including medical history and financial information, as needed
2. Weight and BMI
3. Blood pressure
4. Pap test, if indicated by screening guidelines
5. Chlamydia screening according to screening criteria
6. Fecal occult blood screening for men (should be offered) and women (must be offered) age 50 or over
7. Physical examination, as indicated
8. Post-exam interview/education
9. Supplies as needed
10. Return appointment recommendation or made

C. REVISIT/PROBLEM VISIT

1. Update database
2. Weight, if applicable
3. Blood pressure, if applicable
4. Laboratory tests, as indicated
5. Physical exam, as indicated
6. Post interview/education
7. Supplies

8. Return appointment, as indicated

D. SUPPLY VISITS

1. Record verified for date of last examination
2. Order verified for method, e.g., type of OC, number of cycles already dispensed, and number of cycles left on prescription
3. Update on any problems or concerns

E. VISITS BY CONTRACEPTIVE METHOD

1. Oral contraceptives/contraceptive patch/contraceptive vaginal ring
   a. New to method

      3 cycles, then return for 3-month evaluation. If evaluation satisfactory, then:

      10 cycles (maximum) if method evaluation normal, or

      13-14 cycles if prescribing for extended use of oral contraceptives (12 weeks on 1 week off)

   b. Annual

      Up to 13 cycles (maximum), or

      Up to 16-17 cycles if prescribing for extended use of oral contraceptives, as above

   c. Revisits

      Individual discretion for more frequent visits may be made for special circumstances, (i.e., teens, changing eligibility status, slightly elevated B/P, heavy smoking, etc.) However, dispensing 1 or 2 cycles at a time is viewed as a barrier to continuity of method use. (If the client does not plan to refrigerate, then NuvaRing® should only be dispensed four cycles/rings at a time.)

2. DMPA (Depo Provera® and Depo subQ104 Provera)
   a. Every 11 - 13 weeks for re-injection
   b. Annual visit
   c. Revisits, as needed
3. Implanon
   a. Annual visit
   b. Revisits, as needed
4. IUD
   a. New insertion

      6-12 week post-insertion exam

   b. Annual
   c. Revisits, as needed
5. Diaphragm
   a. Return within 2-4 weeks for evaluation and fit check
   b. Annual or bi-annual visit

   c. Revisits, as needed
6. Spermicide and/or condoms
   a. Annual or bi-annual visit
   b. Revisits, as needed
7. Natural family planning
   a. Annual or bi-annual visit
   b. Revisits, as needed
8. Sterilization
   a. Annual or bi-annual visit
   b. Revisits, as needed

F. PROTOCOL POLICY

1. Mid-level providers will provide medical services according to written, signed protocols.
2. Protocols will be reviewed after additions or revisions by supervising physician and the mid-level provider.
3. Date and signature of physician and mid-level provider(s) will be noted on protocols at review time.
4. Protocols developed by individual practitioners and physicians must be in line with the Program Guidelines for Project Grants for Family Planning Services under Section 1001, Public Health Service Act.
5. Program protocols must be reviewed by the CDPHE Family Planning Program Nurse Consultant.