

Consultants in Pain Management

For Women Only

Pregnancy Consent Form

Patient Name: _____ Account: _____ Date: _____

Due to new regulations from the State of Tennessee, CPM will be requiring a pregnancy test of all women of child bearing years. Your Provider or Provider's Assistant will be addressing this at every visit.

I certify that I have had a hysterectomy _____ Y _____ N Date: _____

I certify that I have had a Tubal Ligation _____ Y _____ N Date: _____

Other sterilization process _____ and do not require a pregnancy test.

Form of contraception: _____

Last Menstrual Period: _____

Patient Signature: _____ **Date:** _____

My consent has been given to receive a pregnancy test. I understand that this testing is required of me to receive any medications from Consultants in Pain Management.

Patient Signature: _____ **Date:** _____

I understand that as part of my Medication Agreement with Consultants in Pain Management I am to notify them immediately if I become pregnant or I am planning to become pregnant.

Patient Signature: _____ **Date:** _____