A Practice Tool for Combined Hormonal Contraceptives

DOCUMENTATION

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Patient Information

NAME: _____ DATE OF APPOINTMENT: _____

TELEPHONE: _____ EXT. _____ DATE OF BIRTH: _____

STEP 1: Assess if CHC is Appropriate

Gather Patient History

AGE: _____

WEIGHT: _____ HEIGHT: _____

MEDICAL HISTORY: _____

Smoking history

Do you currently smoke? ☐ Yes ☐ No

If yes, how many cigarettes do you smoke per day? _____

Screen for contraindications

- ☐ Smokes ≥ 15 cigarettes/day and over the age of 35 years
- ☐ Cardiovascular disease
- ☐ Hypertension (systolic ≥ 140 mmHg or diastolic ≥ 90 mmHg)
- ☐ History of stroke
- ☐ Migraines with aura
- ☐ Diabetes with microvascular complications
- ☐ VTE – current or past history
- ☐ Thrombophilia
- ☐ Breast Cancer – current or past history
- ☐ Active or past liver disease
- ☐ Given birth in the last 3 weeks
- ☐ Breastfeeding <6 weeks postpartum
- ☐ Rheumatic diseases such as lupus
- ☐ Other active cancers/ chemotherapy
- ☐ Undiagnosed abnormal uterine bleeding

Screen for drug interactions

- ☐ Anticonvulsants (phenytoin, carbamazepine, primidone, topiramate, phenobarbital, oxcarbazepine)
- ☐ Rifampin
- ☐ Antiretrovirals (efavirenz, nevirapine ritonavir)
- ☐ St John's Wort
- ☐ Lamotrigine (EE can induce metabolism)

Menstrual history

When was your last menstrual period? _____

How often do you get your periods? (ie. every 28 days) _____

Are your periods ☐ Regular or ☐ Irregular

Are your periods heavy? ☐ Yes ☐ No AND/OR

Do you get spotting in between periods? ☐ Yes ☐ No

If yes to spotting or heavy periods, has it been assessed? ☐ Yes ☐ No

COMMENTS _____

Past & current contraceptive use

What type of contraception are you currently using? _____

Have you been on hormonal contraceptives in the past? ☐ Yes ☐ No
If yes, which ones and for how long? _____

Did you have any side effects? ☐ Yes ☐ No
If yes, please describe: _____

Were you satisfied with past contraceptives? ☐ Yes ☐ No
Why or why not? _____

Were you able to remember to take your contraceptive? ☐ Yes ☐ No

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STEP 1: Assess if CHC is Appropriate

Other reasons for CHC use

Possibility of pregnancy

Have you had unprotected intercourse since your last menstrual period?
☐ Yes ☐ No

Is there a possibility of pregnancy? If yes, recommend pregnancy test.
☐ Yes ☐ No

Assess if LARC is appropriate

Do you want to become pregnant in the next year? ☐ Yes ☐ No
How important is it for you not to be pregnant right now? ☐ Very important ☐ Not that important
Would you be interested in using a LARC?* ☐ Yes ☐ No

* If interested in LARC → Refer.

Perform blood pressure measurement

Blood pressure measurement _____ mmHg

Refer if any of the following

☐ BP is ≥ 140/90 mmHg
☐ Smoker and over 35 years
☐ Abnormal uterine bleeding
☐ One or more contraindications listed above
☐ Potential for drug interaction(s)
☐ Possibility of pregnancy

Assessment

STEP 2: Initiate a CHC Product

Plan

☐ Prescribe
☐ Refer to primary care provider
☐ Make a recommendation

COMMENTS

Prescription (if applicable)

Product name and strength:

Choose a regimen:
☐ Cyclic (21/7)
☐ Shortened HFI (24/4)
☐ Extended cycle
☐ Continuous dosing

Amount prescribed: _____
Refills: _____

STEP 3: Patient Education for CHC

Patient education provided (see patient education checklist or practice tool for details)

☐ Yes ☐ No

COMMENTS

Follow-up plan

Next follow-up:
☐ 1 month
☐ 3 months
☐ Next refill

Method:
☐ Telephone call
☐ In-person

COMMENTS

Pharmacist _____

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Follow-up Monitoring of CHC

NAME: DATE OF FOLLOW-UP:

TELEPHONE: EXT. DATE OF BIRTH:

Assess patient satisfaction

(How do you like your current method of contraception?)

Ask about side effects

Have you experienced any of the following side effects?

- ☐ Breakthrough bleeding
- ☐ Nausea
- ☐ Water retention
- ☐ Headache
- ☐ Mood changes
- ☐ Acne
- ☐ Weight gain
- ☐ Other:

Check adherence

Check if changes with health status

(ie change in medical conditions/medications, smoking status, weight)

☐ Yes ☐ No and if yes, please describe

Perform blood pressure measurement

Blood pressure measurement mmHg

Refer if any of the following:

- ☐ Side effects
- ☐ BP ≥140/90mmHg
- ☐ Abnormal uterine bleeding
- ☐ Adherence issues
- ☐ Contraindications
- ☐ Interested in LARC
- ☐ Other:

Assessment

Plan

- ☐ Continue current CHC
- ☐ Change to a different CHC
- ☐ Refer
- ☐ Manage side effect
- ☐ Other recommendation:

COMMENTS

Prescription (if applicable)

Product name and strength:

Choose a regimen:

- ☐ Cyclic (21/7)
- ☐ Extended cycle
- ☐ Shortened HFI (24/4)
- ☐ Continuous dosing

Amount prescribed:

Refills:

Follow-up Plan

Next follow-up:

- ☐ 1 month
- ☐ 3 months
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Method:

- ☐ Telephone Call
- ☐ In-person

COMMENTS

Pharmacist

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PATIENT EDUCATION CHECKLIST WHEN STARTING COMBINED HORMONAL CONTRACEPTIVES

This checklist includes the general information to provide to patients when starting combined hormonal contraceptives (CHC):

- [ ] How to use CHC
- [ ] When to start CHC (quick start is recommended method)
- [ ] When contraceptive efficacy starts
- [ ] How long to use back-up contraception when starting (for example 7 days after starting)
- [ ] Tips to help remember CHC
- [ ] What to do when CHC dose is missed or delayed
- [ ] Common side effects and management strategies
- [ ] Safe sex practices regarding STI prevention
- [ ] When to seek medical attention

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