



OTTAWA COUNTY HEALTH DEPARTMENT
FAMILY PLANNING PROGRAM
Pills by Mail Form



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 office where you usually go for your exams and contraceptive supplies. (Holland: 616-396-5266; Grand Haven: 616-846-8360; Hudsonville: 616-669-0040)
- Please order pills 10 days 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: _____

What birth control method are you currently using? _____

Do you desire to continue with your present method? Yes No

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

Date your last period started: _____ Was it a normal period? 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: _____

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.

Client Signature _____

Before you may complete your order, you must call to speak to a nurse. Call the office where you usually go for your exams and contraceptive supplies. (Holland: 616-396-5266; Grand Haven: 616-846-8360; Hudsonville: 616-669-0040)

When you call, the nurse will tell you where to mail your request.
 Check the box and use this address to avoid any delays.
 Be sure to send both pages of this form along with payment.

Ottawa County Health Department
 12251 James Street Suite 500
 Holland, MI 49424
 616-396-5266
 Fax 616-393-5659

Ottawa County Health Department
 3100 Port Sheldon Road
 Hudsonville, MI 49426
 616-669-0040
 Fax 616-669-3039

Ottawa County Health Department
 16920 Ferris Street
 Grand Haven, MI 49417
 616-846-8360
 Fax 616-844-1778

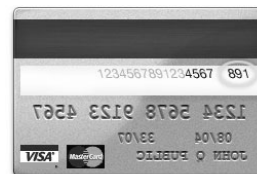
When you call, the nurse will tell you the quantities and fees for your contraceptives.

The maximum number of cycles available _____
 Number of cycles requested _____
 Cost per cycle _____
 Cost of postage and handling _____

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 mail your contraceptives out or prepare them here for you to pick up. If we are unable to fill your contraceptive request we will contact you via phone or mail. **Please, complete both pages of the form.** There is a \$15 fee for returned checks.

DO NOT WRITE IN THIS BOX - FOR OFFICE USE ONLY

Staff Notes:

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