STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
Office of Maternal, Child, and Family Health
Division of Women's and Family Health
WV Family Planning Program

West Virginia Department of HEALTH

CLIENT COUNSELING AND EDUCATION CHECKLIST

Client Name: _____ Date of Birth: _____ Date: _____

BASIC FAMILY PLANNING EDUCATION: (Initial and Annual Visits or as indicated)	Date/ Initial	Date/ Initial	Date/ Initial	Date/ Initial	Date/ Initial
A. Provided counseling and education on all contraceptive methods					
B. Possible side effects/complications of each method					
C. How to discontinue the method selected					
D. Planned return schedule/follow-up visit					
E. Provided emergency telephone number					
F. Provided location where emergency services can be obtained					
G. Referral for additional services as needed					
Counseling for Minors:					
A. Patient was counseled on the benefits of including family in the decision to seek family planning services.					
• Patient advised that parental involvement, knowledge, and/or consent are NOT required to receive services.					
B. Patient was counseled on how to resist coercive attempts to engage in sexual activities.					
Pregnancy Options Counseling: (if indicated)					
A. Negative test result					
• Information provided on contraception and/or infertility services.					
B. Positive Test Result					
• Non-directive, neutral, factual options counseling provided about all options (except for any option which the patient did not wish to receive information)					
C. Referrals given as necessary					

NAME (Please print)	SIGNATURE	CREDENTIALS	DATE