MARYLAND VISIT SUMMARY FORM

This side must be completed if birth control is prescribed

Patient Name_____ Date_____/_____/_____

Today you were prescribed the following birth control:
Medication Name _____
Dosage _____Number of Refills _____

- **Your Pharmacist can answer questions about this birth control. Your Pharmacist is:**
  Pharmacist Name _____
  Phone_____
  Pharmacy Name and Address_____

- **Review this information with your Primary Care Provider (PCP) or Reproductive Health Care Provider. A visit with a Primary Care Provider or Reproductive Health Care Provider is recommended to obtain the recommended tests and screening.**

- **If you do not have a Primary Care Provider or Reproductive Health Care Provider, please consult your Pharmacist for a referral.**

- **Patient: please sign below to indicate that**
  - You understand the information provided.
  - You have received a copy of this visit summary.

_____ _____

Patient Signature **Pharmacist Signature**

MARYLAND VISIT SUMMARY FORM

This side must be completed if birth control is not prescribed

Patient Name_____ Date_____/_____/_____

Today the Pharmacist could not prescribe birth control due to one or more health concerns.

- □ Your blood pressure was above 140/90 mmHg. Today_____/_____ mmHg
- □ You take medications or supplements that may interfere with birth control.
- □ You have a condition that may interfere with the safe use of birth control.
- □ You may be pregnant.
- □ Other: _____

- **Your Pharmacist can answer questions about this visit. Your Pharmacist is:**
  Pharmacist Name _____
  Phone_____
  Pharmacy Name and Address_____

- **You may still be eligible for prescription birth control**.

- **Review this information with your Primary Care Provider (PCP) or Reproductive Health Care Provider. A visit with a Primary Care Provider or Reproductive Health Care Provider is recommended to obtain the recommended tests and screenings.**

- **If you do not have a Primary Care Provider or Reproductive Health Provider, please consult your Pharmacist for a referral.**
  - Most women should have a reproductive health review each year.

- **Patient: please sign below to indicate that**
  - You understand the information provided.
  - You have received a copy of this visit summary.

_____ _____

Patient Signature **Pharmacist Signature**