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	Document Title:	FAMILY PLANNING SERVICES

PURPOSE:

1. To establish clear process guidelines for providing quality family planning services to Reproductive Health Unit (RHU) clients.
2. To serve as a reference for the Obstetric and Gynecology Department and the RMCI Reproductive Health Unit (RHU) personnel on the implementation of the Family Planning Services.

SCOPE:


Covers the Reproductive Health Unit of Riverside Medical Center, Inc. under the management of the Department of Obstetrics and Gynecology, in collaboration with the Nursing Service Division and its Delivery Room Unit.

PERSON RESPONSIBLE:

OB-Gyne Resident Physician on duty (ROD), RHU personnel on duty

GENERAL GUIDELINES:

1. All RMCI RHU clients must first be seen by the RHU personnel on duty to undergo an initial interview and have their vital signs taken.
2. All Family Planning clients must sign a program enrollment form and consent to undergo Family Planning counseling prior to undergoing any Family Planning counseling and intervention.
3. The Client Assessment Record must be accomplished by the ROD as part of the client's record/chart.
4. A client record/logbook must be maintained at the RHU clinic containing details on the patient's name and address, date of visit, Attending Resident physician on duty during the visit, type of care and/or counseling or topic provided, and the date of the follow-up visit.

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5. CONTENT/ TOPIC FOR EDUCATION AND COUNSELING:


The Family Planning counseling includes education on birth spacing, different types of contraceptives, infection prevention and control, management of contraceptive side effects, and referral process for government-managed family planning health centers.

6. SERVICES OFFERED:


- a) Risk Assessment through Physical Exam
- b) Family planning education and counseling
- c) IUD Insertion
- d) DPMA injection
- e) Management referral of complications
- f) Diagnosis and management of RTIs, Cancer screening (Acetic acid wash/ Pap smear
- g) Referral for BTL
- h) Routine check-ups
- i) Counseling on infertility

PROCEDURE:

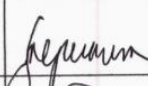
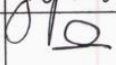
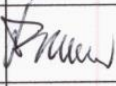
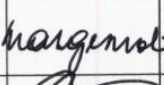
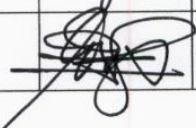
1. Interview the Family Planning client to get the general information, then take vital signs
2. Fill out the first part of the Family Planning Enrollment Sheet (see Annex A).
3. Ensure that the consent form (See Annex B) is signed by the client prior to endorsement to the Resident Physician On-Duty (ROD).
4. Endorse the client to the ROD along with the partially filled FPES and the consent form.
5. The ROD conducts initial health screening and assessment, history taking.
6. After an initial assessment, the ROD conducts family planning education and counseling.
7. The ROD accomplishes the Family Planning Client Assessment Record (Annex C) and completes the FPES.


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8. Should the patient needs referral and/or follow-up consultation, the ROD prepares the document and advise the client on the date of the next visit and or schedule of the procedure.
9. The nurse reviews the client's chart and logs the patient on the list of Family Planning Clients List.



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APPROVAL:


	Name/Title	Signature	Date
Prepared by:	MARIA LIZA C. PERAREN, RN, MAN Nursing Director		4-9-2022
Reviewed:	DENNIS C. ESCALONA, MN, FPCHA, FPSQua Quality Assurance Supervisor		04-09-2022
Recommending Approval:	HENRY F. ALAVAREN, MD, FPSMID, FPSQua Total Quality Division Officer		4/8/2022
	MA. ANTONIA S. GENSOLI, MD, FPPS, FPCHA Vice President – Chief Medical Officer		4-6-22
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO		4/6/22

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ANNEX A:

 <p>RIVERSIDE MEDICAL CENTER, INC. Owner and Operator of the Dr. Pablo O. Torre Memorial Hospital A proud member of the Metro Pacific Hospital Holdings, Inc.</p>																
FAMILY PLANNING ENROLLMENT SHEET																
GENERAL INFORMATION																
NAME OF RESPONDENT: _____ <div style="display: flex; justify-content: space-between;"> Last Name Given Name MI Date of Birth Age Educ. Attain. Occupation </div>																
ADDRESS: _____ <div style="display: flex; justify-content: space-between;"> No. Street Barangay Municipality Province Contact Number Civil Status Religion </div>																
NAME OF SPOUSE: _____ <div style="display: flex; justify-content: space-between;"> Last Name Given Name MI Date of Birth Age Occupation </div>																
NO. OF LIVING CHILDREN: ____ PLAN TO HAVE MORE CHILDREN? Yes No AVERAGE MONTHLY INCOME: ____																
Type of Client <input type="checkbox"/> New Acceptor Reason for FP: <input type="checkbox"/> spacing <input type="checkbox"/> limiting <input type="checkbox"/> others Method Currently used (for Changing Method) <input type="checkbox"/> Current Use <input type="checkbox"/> COC <input type="checkbox"/> IUD <input type="checkbox"/> LAM <input type="checkbox"/> BBT <input type="checkbox"/> Changing Method. Reason: <input type="checkbox"/> Medical Condition <input type="checkbox"/> Side effects <input type="checkbox"/> Implant <input type="checkbox"/> Condom <input type="checkbox"/> Injectable <input type="checkbox"/> POP <div style="text-align: center;">CMM</div>																
OBSTETRICAL HISTORY: Number of pregnancies: G ____ P ____ ____ Full term ____ Premature ____ Abortion ____ Living Children Date of last delivery ____/____/____ Type of last delivery ____ Vaginal ____ Cesarean Section LMP ____/____/____ PMP ____/____/____		MEDICAL HISTORY: <input type="checkbox"/> Severe headaches / migraine <input type="checkbox"/> Hypertension <input type="checkbox"/> Frequent Bruising or gum bleeding <input type="checkbox"/> Current history of breast cancer/ breast mass <input type="checkbox"/> Severe chest pain <input type="checkbox"/> Cough for more than 14 days <input type="checkbox"/> Jaundice <input type="checkbox"/> Unexplained vaginal bleeding <input type="checkbox"/> Abnormal vaginal discharge <input type="checkbox"/> Is the client smoker?														
PHYSICAL EXAMINATION: BP: _____ Temp: _____ RR: _____ HR: _____ Weight (kg): _____ Height: _____ SKIN: _____ CONJUNCTIVA: _____ NECK: _____ BREAST: _____ ABDOMEN: _____ EXTREMITIES: _____		PELVIC EXAMINATION: <table border="1" style="width: 100%;"> <tr> <td>Injectables</td> <td></td> </tr> <tr> <td>Implant</td> <td></td> </tr> <tr> <td>Lactation amenorrhea method</td> <td></td> </tr> <tr> <td>Basal body temperature</td> <td></td> </tr> <tr> <td>Condom</td> <td></td> </tr> <tr> <td>Standard days method</td> <td></td> </tr> </table>	Injectables		Implant		Lactation amenorrhea method		Basal body temperature		Condom		Standard days method			
Injectables																
Implant																
Lactation amenorrhea method																
Basal body temperature																
Condom																
Standard days method																
FAMILY PLANNING METHOD: <table border="1" style="width: 100%;"> <tr> <td>Female Sterilization</td> <td></td> </tr> <tr> <td>Male Sterilization</td> <td></td> </tr> <tr> <td>Progestin only pills</td> <td></td> </tr> <tr> <td>Combined oral contraceptive pills</td> <td></td> </tr> <tr> <td>Interval IUD</td> <td></td> </tr> <tr> <td>Postpartum IUD</td> <td></td> </tr> <tr> <td>Cervical Mucus method</td> <td></td> </tr> </table>		Female Sterilization		Male Sterilization		Progestin only pills		Combined oral contraceptive pills		Interval IUD		Postpartum IUD		Cervical Mucus method		
Female Sterilization																
Male Sterilization																
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Combined oral contraceptive pills																
Interval IUD																
Postpartum IUD																
Cervical Mucus method																
Assessed by: _____		Year Level: _____														
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ANNEX B:

 <p>DR. PABLO O. TORRE MEMORIAL HOSPITAL</p>	<h1>RIVERSIDE MEDICAL CENTER, INC.</h1> <p>Owner and Operator of the Dr. Pablo O. Torre Memorial Hospital A proud member of the Metro Pacific Hospital Holdings, Inc.</p>	
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FAMILY PLANNING COUNSELLING INFORMED CONSENT

I consent to the Family Planning counselling which will be provided to me by my attending physician. I understand that Family planning counselling is a continuous process that will allow my counsellor to help me make and arrive at informed choice about the size of my family.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost.

I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this Family Planning Counseling.


Participant's Signature: _____ Date: _____

Counsellor's Signature: _____ Date: _____



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ANNEX C:

 <p>RIVERSIDE MEDICAL CENTER, INC. Owner and Operator of the Dr. Pablo O. Torre Memorial Hospital A proud member of the Metro Pacific Hospital Holdings, Inc.</p>					
<p>Name of Patient: _____</p> <p>Age: _____</p> <p>OB Score: _____</p> <p>Address: _____</p> <p>Contact number: _____</p> <p>Email address: _____</p>					
FAMILY PLANNING CLIENT ASSESSMENT RECORD					
DATE OF VISIT (MM/DD/YYYY)	MEDICAL FINDINGS (service rendered/ procedures, laboratory examination, treatment and referrals)	METHOD ACCEPTED	COMPLAINTS/ COMPLICATIONS	NAME AND SIGNATURE OF RESIDENT IN CHARGE	DATE OF FOLLOW-UP VISIT (MM/DD/YYYY)

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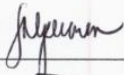


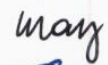

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KEY TASKS	PERSON RESPONSIBLE
1. Interviews the Family Planning client to get the general information, then takes the vital signs.	RHU personnel on duty
2. Fills out the first part of the Family Planning Enrollment Sheet.	
3. Ensures that the consent form is signed by the client prior to endorsement to the Resident Physician On-Duty (ROD).	
4. Endorses the client to the ROD along with the partially filled FPES and the consent form.	
5. Conducts initial health screening and assessment, history taking.	ROD
6. Conducts family planning education and counseling.	
7. Accomplishes the Family Planning Client Assessment Record and completes the FPES.	
8. Prepares the document and advise the client on the date of the next visit and or schedule of the procedure.	RHU personnel on duty
9. Reviews the client's chart and logs the patient on the list of Family Planning Clients List.	

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APPROVAL:

	Name/Title	Signature	Date
Prepared by:	MARIA LIZA C. PERAREN, RN, MAN Nursing Director		5-11-2022
Reviewed:	DENNIS C. ESCALONA, MN, FPCHA, FPSQua Quality Assurance Supervisor		5-12-2022
Recommending Approval:	HENRY F. ALAVAREN, MD, FPSMID, FPSQua Total Quality Division Officer		6-2-2022
	MA. ANTONIA S. GENSOLI, MD, FPPS, FPCHA Vice President – Chief Medical Officer		6-6-22
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO		6/15/22

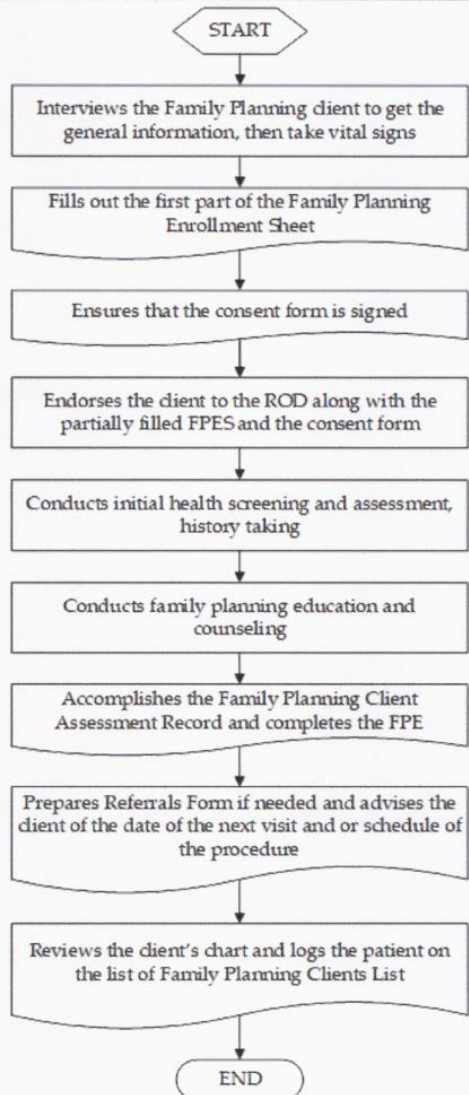



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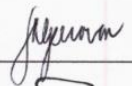

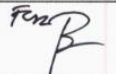
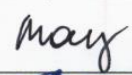
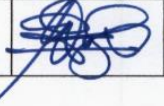
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FLOWCHART



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APPROVAL:

	Name/Title	Signature	Date
Prepared by:	MARIA LIZA C. PERAREN, RN, MAN Nursing Director		5-11-2022
Reviewed:	DENNIS C. ESCALONA, MN, FPCHA, FPSQua Quality Assurance Supervisor		5-11-2022
Recommending Approval:	HENRY F. ALAVAREN, MD, FPSMID, FPSQua Total Quality Division Officer		6/2/22
	MA. ANTONIA S. GENSOLI, MD, FPPS, FPCHA Vice President – Chief Medical Officer		6-6-22
Approved:	GENESIS GOLDI D. GOLINGAN President and CEO		6/15/22