

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 ≥ 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

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 $\geq 140/90$ 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)

☐ Extended cycle

☐ Shortened HFI (24/4)

☐ 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

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 ☐ Water retention ☐ Mood changes ☐ Weight gain
☐ Nausea ☐ Headache ☐ Acne ☐ 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 ☐ Abnormal uterine bleeding ☐ Contraindications ☐ Other:
☐ BP $\geq 140/90$ mmHg ☐ Adherence issues ☐ Interested in LARC

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) ☐ Shortened HFI (24/4)
☐ Extended cycle ☐ Continuous dosing

Amount prescribed:

Refills:

Follow-up Plan

Next follow-up:

☐ 1 month
☐ 3 months
☐ Next refill

Method:

☐ Telephone Call
☐ In-person

COMMENTS

Pharmacist

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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