Include this form in the patient's medical record

PATIENT LAST NAME: _____
PATIENT FIRST NAME: _____
DOB: ___/___/_____
DATE OF VISIT: ___/___/_____

Care Checklist for Patients with Female Genital Mutilation/Cutting

Use this checklist to track care related to a patient's FGM/C concerns.

1. Did you discuss FGM/C with your patient during THIS visit? Yes ___ No___ Date _____
2. Did you discuss FGM/C during a PREVIOUS visit? Yes ___ No___
3. Who first raised FGM/C? Patient/ Provider
4. Did you fill out the Risk Assessment forms before determining that FGM/C is a health concern for your patient: Yes ___ No___ Date, if completed____
5. Age of patient when she was cut: _____
6. Are other female family members cut? _____
7. Does the patient have daughters who may be at risk of FGM/C? Yes ___ No___
   Use child risk assessment form to help you determine if the child is at risk.
8. Did you perform a pelvic exam? Yes ___ No ___ Date, if completed _____
   a. If known, what type of FGM/C? _____
   b. Difficulty with speculum exam?
      Describe: _____
9. Did you discuss any of these FGM/C health complications?
   ___ Painful intercourse
   ___ Difficulty urinating
   ___ Bladder infections
   ___ Anxiety
   ___ Depression
   ___ Pregnancy
      Ask about labor/delivery plan?
   ___ Previous pregnancies?
      Number of pregnancies: ___
      Vaginal deliveries: Yes ___ No___
   ___ Pregnancy concerns? Describe: _____
   ___ Other concerns? Describe: _____
10. If patient had a previous pregnancy, did she have:
    Episiotomy? Yes ___ No___
    Anxiety about labor and delivery? Yes ___ No___
    C-section? Yes ___ No___
    Concerns about ability to get pregnant? Yes ___ No___
    Describe:_____

For future visits

____ Discuss ongoing concerns.
Describe: _____
____ Discuss future pregnancy intentions, if applicable
____ Any follow-up needed?
Describe: _____
___ Any continuing treatment?
Describe: _____
___ Patient says FGM/C not a current concern
___ Referrals
Describe: _____