

PATIEN	IT LAST NAME:			
PATIEN	IT FIRST NAME:			
DOB: _				
DATE C	DF VISIT:/			
	Care Checklist for Patients with Female Genital Mutilation/Cutting			
Use thi	is 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 concerr 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?			

If patient had a previous pregnancy, did she have:
 Episiotomy? Yes \_\_\_\_ No\_\_\_
 Anxiety about labor and delivery? Yes \_\_\_\_ No\_\_\_

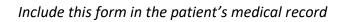
Number of pregnancies: \_\_\_\_ Vaginal deliveries: Yes \_\_\_\_ No\_\_\_

\_\_\_\_ Previous pregnancies?

C-section? Yes \_\_\_\_ No\_\_\_ Concerns about ability to get pregnant? Yes \_\_\_\_ No\_\_\_

Pregnancy concerns? Describe:
Other concerns? Describe:

Describe:





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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 cor	ncern
Referrals	
Describe:	