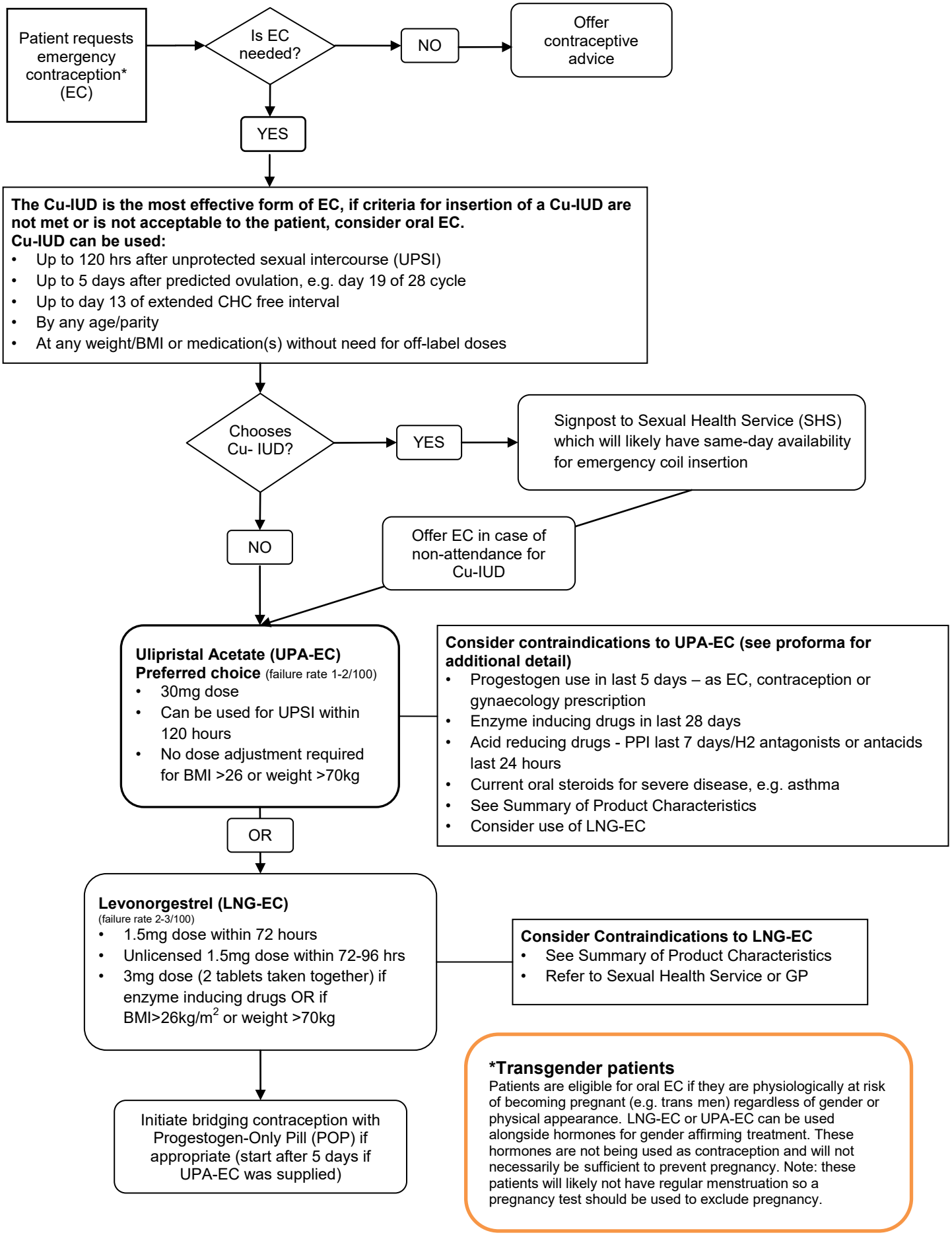
Flowchart for Oral Emergency Contraception (EC): Ulipristal Acetate (UPA-EC) versus Levonorgestrel (LNG-EC) **if** Cu-IUD is not appropriate or acceptable**.**
NB: Oral EC is unlikely to be effective if **taken after ovulation.**



***Transgender patients**
Patients are eligible for oral EC if they are physiologically at risk of becoming pregnant (e.g. trans men) regardless of gender or physical appearance. LNG-EC or UPA-EC can be used alongside hormones for gender affirming treatment. These hormones are not being used as contraception and will not necessarily be sufficient to prevent pregnancy. Note: these patients will likely not have regular menstruation so a pregnancy test should be used to exclude pregnancy.

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Adapted from North of Scotland EHC flowchart and pro forma

Emergency Contraception Pro forma

Consultation Details

Healthcare Professional Name (PRINT):	Date of Consultation:
Patient Name:	Date of Birth: Age:
Patient aged 13 years or over and competent to consent? Yes ☐ No ☐	
If No or child protection issues: follow local child protection guidance and refer to local service	

Circumstances Leading to EHC Request

UPSI
Time since UPSI? ☐ <72 hrs ☐ 72-96 hrs ☐ 96-120 hrs ☐ >120 hrs (may warrant referral to local SHS)

History		**Action/Information**
Day 1 of last menstrual period (LMP)	/ /	This allows calculation of place in the cycle. Oral EC after ovulation (days 9-16) can be given but is likely to be ineffective and a Cu-IUD should be used.
LMP regular? (See info for trans patients on flowchart)	Yes ☐ No ☐	
Given birth within the last 3 weeks?	Yes ☐ No ☐	If yes EC is not required. **Note:** Early pregnancy loss **does** require EC.
Any other episodes of UPSI since last menstrual period?	Yes ☐ No ☐	Consider possibility of pregnancy and if necessary signpost to GP/SHS.
Has the patient taken LNG-EC or another progesterone within the last 7 days?	Yes ☐ No ☐	If yes then UPA-EC is less effective, advise Cu-IUD or use LNG-EC.
Are there any concerns in regard to unsafe relationships/child abuse/adult protection concerns?	Yes ☐ No ☐	If yes contact relevant local service.

Medical History	**Yes**	**No**	**Action/Information**
Allergy to UPA-EC or LNG-EC?			If yes advise Cu-IUD and signpost for fitting. If declined refer to GP or Sexual Health Service (SHS).
Current unexplained vaginal bleeding?			If yes signpost to GP or Sexual Health Service (SHS) or Out of Hours
BMI >26kg/m^2 or >70kg in weight			If yes advise Cu-IUD (first line), UPA-EC if suitable or LNG-EC 3000 microgram dose (unlicensed).
Currently breastfeeding?			LNG-EC or IUD*. Advise to discard breast milk for 7 days after UPA-EC use. *Increased risk of intrauterine perforation with IUD – would be for discussion at SHS.
Current severe disease treated with oral glucocorticoids e.g. asthma?			If yes UPA-EC not suitable, consider LNG-EC if UPSI is <96 hours or refer to GP or SHS if greater.
Severe malabsorption syndrome e.g. Crohn's disease or severe diarrhoea?			If yes signpost for Cu-IUD as LNG-EC and UPA-EC may be less effective.
Porphyria?			If yes UPA-EC is not suitable – advise Cu-IUD or use LNG-EC.
Currently taking medicines that increase gastric pH?			UPA-EC will have a reduced effect if PPI taken in the last 7 days or H2 antagonist or antacid taken within the last 24 hours.
Currently taking enzyme inducing medication including St. John's Wort?			If yes UPA-EC is not suitable. The only licensed option is an IUD or consider LNG-EC 3000 microgram dose (unlicensed).
Other significant drug interactions			If interaction cannot be managed then refer to SHS or relevant specialist.

Refer to flowchart for choice of UPA-EC/LNG-EC/Cu-IUD depending on the answers provided above

Counselling Checklist to be Discussed Prior to Treatment	
Pregnancy Risk:	
Days 9-16 of /28 cycle	20-30% risk of pregnancy with x 1 UPSI
Days 1-8 and >16 of /28 cycle	2-3% risk of pregnancy with x 1 UPSI
LNG-EC within 96 hours	2-3 in 100 women will become pregnant
UPA-EC within 120 hours	1-2 in 100 women will become pregnant
Copper IUD up to 120 hours after UPSI / or ovulation	< 1 in 100 women will become pregnant

☐	Cu-IUD discussed as most effective 1st line option	☐	Mode of action, efficacy and failure rates (see above)
☐	Action if vomiting occurs within 3 hours (return for an additional dose)	☐	Explain any common side effects
☐	If EC fails there is no increased risk of foetal abnormality	☐	Next period may be late/early and light bleeding may occur over the next few days (not to be counted as a period)
☐	Return if there is a further episode of UPSI	☐	Patient to read the PIL for the EC
☐	When to seek medical advice i.e. should severe abdominal pain occur	☐	If no normal menstrual period within 3 weeks take pregnancy test

Contraception Advice (when appropriate)	
Bridging/Quick Start Contraception Discussed Yes ☐ No ☐	Barrier methods discussed Yes ☐ No ☐
☐ Client declined ongoing contraception/advice	☐ Bridging contraception supplied (desogestrel)

Outcome of consultation (tick all that apply)			
☐	Signposted for Cu-IUD insertion	☐	No EC required
☐	LNG-EC 1500 microgram single dose under PGD Batch No:	☐	UPA-EC 30mg single dose Batch No:
☐	LNG-EC 3000microgram single dose under PGD (unlicensed) Batch No:	☐	EC not indicated and declines Cu-IUD (Refer to SHS or GP)

Referral	Signposted to Sexual Health Service ☐	Signposted to Out of Hours Service ☐	Signposted to GP ☐

Consent			
Emergency hormonal contraception treatment risks have been fully explained to me and I agree to treatment. I have been informed of how my data will be stored and who will be able to access that information, as well as how it may be used.			
Patient Signature		Date	
Healthcare Professional Supplying Signature		Date	