All Women's Health

Informed Consent

FOR ABORTION TREATMENT,
ANESTHETIC ADMINISTRATION, LAMINARIA INSERTION
AND OTHER MEDICAL SERVICES DEEMED NECESSARY

DATE_____

NAME_____AGE_____DOB_____
Last First MI
ADDRESS_____CITY_____STATE_____

Work Phone_____Home Phone_____Instructions to Call You_____

Please list 2 persons that may be contacted in case of emergency:

NAME	ADDRESS	PHONE	RELATIONSHIP	ARE THEY AWARE? YES NO

NAME	ADDRESS	PHONE	RELATIONSHIP	ARE THEY AWARE? YES NO

I, _____request and consent to the performance upon me of a pregnancy termination procedure by vacuum aspiration (suction abortion) or dilation and evacuation (D&E). I also consent to the insertion of osmotic dilators if deemed necessary. I affirm this to be my personal choice with the understanding that I have the alternative to continue the pregnancy. No one has coerced or forced me to make this decision.

I further consent to the taking of cultures and the performance of reasonable indicated tests and procedures, to include, but not be limited to ultrasound examination, laminaria insertion if found advisable or necessary for pregnancy termination or management of complications. If laminaria are inserted, I understand that the pregnancy may have been interrupted and I must return for the completion of the abortion procedure.

I have completely disclosed my medical history including allergies, medications, drugs taken, and any history of adverse reactions to local anesthetics, medicines, or drugs. I consent to the physician relying on this disclosure as complete.

I understand that local anesthetics and/or pain medications do not always eliminate all pain and cramping, and that in a small number of cases severe reactions, including shock and death have occurred. No guarantees to the contrary have been made to me.

I consent that the physician or assistants may administer such anesthetics and medications as may be deemed necessary or advisable.

The first day of my last normal menstrual period was _____, _____

This period was (circle one) normal heavy light

The period before that was (circle one) normal heavy light

My periods during the last six months have been (circle one) regular irregular

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My periods during the last six months have been (circle one) normal heavy light absent

I understand that information concerning my last period is important to the diagnosis and method of treatment. I consent to treatment based upon my recollections as stated above in combination with the results of ultrasound and pelvic examination.

I understand that tissue and parts will be removed during the procedure, and I consent to their examination by the physician, assistants, or pathologist. I consent to their disposal by the clinic in a manner deemed appropriate.

I understand that the complications associated with early pregnancy termination are generally much less severe and less frequent than with childbirth. Nonetheless, I realize, as is true with childbirth, or any kind of surgery that there are inherent risks of minor and major complications which may occur without the fault of the physician. I understand that there are other risks that exist in any surgical procedure. These risks include, but are not limited to, severe loss of blood, the possibility of blood transfusions and complications arising therefrom, infection, cardiac arrest, cardiac arrhythmias, stroke and embolism. The risks of terminating your pregnancy gradually increase the later in the pregnancy you are, and become approximately equal to a normal childbirth at 16-18 weeks gestation.

The risks and possible complications of the abortion procedure most likely to occur, THOUGH ONLY IN A SMALL NUMBER OF CASES, are as follows: (in approximately decreasing order of frequency)

Post abortion syndrome: In a few cases the uterus bleeds and forms clots that are retained inside, more commonly in a tipped uterus in early pregnancy cases. As the uterus reacts to the clots by cramping to expel the clots, resulting in increasingly severe cramping and pain. To relieve the pain, and empty the uterus, occasionally a repeat suction procedure must be done (unless the uterus successfully expels the clots). This complication usually occurs within a few hours after the abortion.

Infection: Caused by the inevitable presence of bacteria in the vagina, gaining access to the uterus, is reported in a small percentage of cases. You will be given an antibiotic to take to decrease the chance of infection. Most infections respond to outpatient antibiotics, but occasionally hospitalization is necessary.

Bleeding: In a few cases, usually after 12 weeks, there is more bleeding than expected. This may require an immediate repeat of the procedure or hospitalization for observation and treatment. If this excessive bleeding occurs after the abortion, hospitalization and possible transfusion of blood and dilation and curettage (D&C) may Have to be performed to remove an incomplete abortion or retained material in the uterus.

Laceration: Occasionally the cervical opening and or cervical canal may be torn. Usually only a few stitches are necessary to repair the tear. However, this complication can cause sever bleeding and require hospitalization.

Perforation: Rarely, an instrument used in the abortion procedure may go through the wall of the uterus. Should this occur, hospitalization would usually be necessary for observation, completion of the procedure, and possible repair of the uterus or any damaged surrounding organs.

Failure to Terminate Pregnancy: In a very small percentage of early pregnancies the abortion procedure fails to end the pregnancy, or an incomplete abortion results. If this should occur, another abortion procedure, usually a repeat vacuum aspiration would be recommended because the first attempt may have prevented normal development of the pregnancy.

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Hysterectomy: This is the removal of the uterus. As a result of pre-existing conditions or some of the above complications (perforation, bleeding, infection) a hysterectomy may be necessary, but extremely rarely.

Tubal pregnancy: This is not a risk or a complication of the abortion procedure, but approximately 1 in every 100 pregnancies is located outside of the uterus. If this condition goes undiagnosed and treated, it will likely lead to catastrophic rupture of the tube which carries a high mortality. Therefore ALL ectopic pregnancies must be surgically removed. This would require hospital admission and could not be done by the abortion procedure. I understand that this is a pre-existing medical condition and that the physician assumes no medical or financial responsibility.

Parental Notification: Is inevitable in the event of significant complications.

Long term risks: There is no evidence that having an abortion increases your chances of subsequent infertility, miscarriage, or ability to have a normal future pregnancy.

I understand that the physician, counselor or assistants will answer any questions that I have, and that I will ask all questions before leaving the office. If I have questions or complications after leaving, I agree to call the clinic immediately. I agree to have an examination and or pregnancy test within 2-3 weeks of the termination to rule out continued pregnancy or the existence of other problems.

I understand that I may be treated for any resulting complications at All Women's Health, PS, at no additional charge to me. However, if hospitalization is required, or if I should go to another physician or healthcare facility then I will be responsible for all charges.

I further understand that the medical practices of the physician are to be judged according to those standards reasonably acceptable to other physicians practicing in similar U.S. facilities.

I certify that I have read, had explained to me, and fully understand the informed consent that I am signing, and I agree, in light of that consent, to the pregnancy termination procedure that I have requested. I understand that I may have a copy of this consent form at my request.

If requested or necessary, I authorize you to send a copy of my medical records or other information to the referring health care provider, my insurance carrier, or to Hospital or Emergency Room personnel.

Date_____Time_____AM/PM

X _____
Signature of Patient

_____
Witness

I have explained the consent, instructions, and the procedure to this patient. She understands the materials and consents under the above conditions.

_____
Interpreter Relation