Women’s World Medical Center, Inc.

Medical Abortion Risks, Benefits and Alternatives

ALTERNATIVES: Women who are pregnant can decide to continue or end the pregnancy and, depending on the outcome of the pregnancy, can then decide to parent or place the child for adoption. Each option will have benefits and risks. If a pregnancy is less than 9 weeks, you have the additional choice of a medical or surgical abortion. You need to consider your choices carefully to be able to make the best decision for yourself.

BENEFITS: Abortion, adoption, and parenting can each have benefits, depending upon the individual, the timing of the pregnancy, and the situation. The benefits of carrying to term or having an abortion can be different for each person. Medical abortion may have other perceived benefits, such as the ability to take the second medicine (misoprostol) outside the clinic, with a chance for increased privacy and comfort during the abortion process.

RISKS: Abortion using mifepristone and misoprostol is a simple medical procedure. Like any procedure, it is possible that a complication could occur during or after your procedure and require treatment. It is important to know about risks and include this information as part of your decision. Possible risks include but are not limited to the following. There is always a risk of previously unknown side effects occurring including death. However, many (tens of thousands) women have had a similar medical abortion procedure in this country alone, and the medical abortion process has been studied and reported on for over 17 years around the world.

Please initial each blank after reading the corresponding information.

____ MIFEPRISTONE can cause nausea, vomiting, diarrhea and fatigue. These effects are mild, usually last less than three days, and the nausea/vomiting may be helped with medication.

____ MISOPROSTOL can also cause nausea, vomiting and diarrhea and is expected to cause uterine cramps (lower abdominal pain) for less than three days similar or worse than a menstrual period. The cramping pain may be helped with over the counter or prescription pain medicines. DO NOT TAKE ASPIRIN for pain as it can thin your blood and increase bleeding.

____ INCOMPLETE ABORTION: It is possible for part of the pregnancy tissue to still be inside the uterus after the abortion. This happens in about 2-5% of patients and is treated by a surgical completion of the abortion. Incomplete abortion can lead to serious bleeding (hemorrhaging requiring a transfusion), infection, and severe abdominal pain. It is very important to return for your follow-up ultrasound. This checkup is provided to you at no additional charge at A Woman’s World Medical Center, Inc.

____ CONTINUING PREGNANCY: In rare cases (about 1% of the time) a woman can still be pregnant after an abortion. Possible causes include: a twin or multiple pregnancy, early pregnancy, a tubal pregnancy (ectopic), or an abnormality of the uterus. A tubal pregnancy is a medical emergency that would require immediate further testing, treatment, possible hospitalization and surgery. These problems may be discovered at the time of the follow-up visit. If the pregnancy is continuing, you will need to have a surgical abortion. This will be provided at no additional charge if done at A Woman’s World Medical Center.

Patient Signature ___________________________ Date ___________________
INFECTION: In a small number of cases the uterus or pelvic organs could become infected after an abortion. Medication can treat infection, causing no long-term damage, if the woman seeks medical attention in the early stages of infection. In some cases an infection may be serious enough to cause permanent damage, such as loss of the ability to have children. Call us immediately if you think you have any of these symptoms of infection: **bad smelling vaginal discharge, temperature of 100.4 or above lasting more than 2 hours, or severe abdominal pain.**

BLEEDING OR HEMORRHAGE: Very heavy bleeding can occur during or after the abortion. Treatment depends on the cause of the bleeding and can include but is not limited to observation, medication, hospitalization, transfusion or further surgery. The risk of hemorrhage (defined as needing a blood transfusion) is less than one-half of one percent (2-4 per 1000 women, depending on gestation.) It is important for you to **contact us if you soak 2 or more pads in an hour for 2 hours or more, or if your bleeding lasts for more than 4 weeks.**

AMNIOTIC FLUID EMBOLISM OR ANAPHYLACTIC CONDITION OF PREGNANCY: This is extremely rare, pregnancy-related complication can occur during childbirth, miscarriage or abortion. Current theory suggests antibodies from the fetus create an allergic reaction in the woman’s heart, causing her heart to stop, and resulting in coma or death. It is not predictable or preventable.

POST-ABORTION SYNDROME: This is a physical condition occurring when the uterus fills with blood clots that do not pass through the cervix and create severe cramping. Uterine massage, medication or surgical evacuation of the uterine contents are all possible treatments.

MORTALITY RISK: Although there is a risk of death as a result of an abortion, there is also a risk of death from childbirth. The risk of death from childbirth is much greater than from a first trimester abortion (through 14 weeks.) In the United States there is less than 1 death for every 100,000 first trimester abortion procedures performed.

BREAST CANCER: NO PROVEN LINK. Although some studies suggest there is a link between abortion and breast cancer, the World Health Organization, American Cancer Society and the National Cancer Institute conclude that there is no proven evidence of abortion causing breast cancer.

**Acknowledgment of Understanding**

*I have read and understand the possible risks, benefits and alternatives to abortion. I have discussed these and asked any questions of the A Woman’s World Medical Center staff and/or doctor before my procedure that I felt I needed to. I understand I may need additional tests or treatment as a result of the pregnancy or abortion for my physical well-being, and I accept the responsibility for additional expenses that these tests or treatment may require.*

Signature of Patient ___________________________________________ Date ________________

Witness Signature _____________________________________________ Date ________________
A Woman's World Medical Center, Inc.

Patient Consent to Treatment, Anesthetics, and Other Medical Services

Please initial each blank after reading the corresponding information.

I, _______________________, take full responsibility for this decision and agree to medical and surgical procedures to attempt to end my pregnancy. I agree to be treated by a A Woman’s World Center’s physician (Dr. ___________).

I agree to have a blood sample taken to test for anemia and the Rh factor. It has been explained to me that if my blood is RH negative, I will be required to receive a shot of Rhogam or microgam (Rho D Immune Globulin) immediately following my abortion. I understand that this will help prevent serious problems in future pregnancies pertaining to my blood type. I understand that additional samples and tests may be needed if my physical safety or the law requires it.

I agree to the doctor or the doctor's assistant giving me anesthesia, pain relievers, or other medication they feel are necessary for my care. I am allergic to: __________________________ (none, local, systemic, or general anesthesia, other).

I understand that the fetal tissue removed during the abortion may be sent to a laboratory for pathology examination. The tissue will be disposed of by the clinic or the lab following legal and sanitary guidelines.

I understand that if a major problem occurs during or after my abortion, I may need to be hospitalized and perhaps require additional surgery. I agree to have any such treatment that the doctor judges to be necessary for my well-being.

I give my permission to A Woman’s World Medical Center to request my medical records from any health provider who treats me for a complication.

I have read (or had read to me) the patient information sheets and was given the opportunity to ask questions. I understand the abortion procedure.

Acknowledgment of Possible Emotional Risks

I understand that research has shown the majority of women experience feelings of relief and have no major regret after an abortion. However, some women MAY and do experience guilt, sadness, depression, and/or regret following an abortion, just as they may experience these feelings after giving birth. I understand these feelings can range from mild to severe, and if I need further counseling following the abortion, I take responsibility for seeking and getting emotional care. A Woman’s World Medical Center, Inc. has given me the opportunity to talk and ask questions concerning my feelings about the abortion.

I have read and understand the patient consent to treatment and I understand the possible risks.

Signature of Patient __________________________ Date ________________

Witness __________________________________ Date ________________
MEDICAL HISTORY

BLOOD TYPE __________________
SS# __________________

NAME ___________________ AGE _______ DATE OF BIRTH ________

ADDRESS

STREET ___________________ CITY ______ STATE ______ ZIP ______

Telephone
H(_____) Cell(_____) W(_____)

What is your occupation? __________________ Describe your job to us

List names and relationships of people we can NOT talk to

Are You interested in birth control? Y or N type __________________
Are you presently taking birth control pills? Y or N type __________________
First day of your last normal period? __________________
Do you usually have cramps with your period? Y or N Mild ______ Medium ______ Severe ______
Do you usually have clots with your period? Y or N __________________
Do you have any allergies to medications? Y or N type __________________
List any medications you are currently taking? __________________
Do you smoke? Y or N how many years? __________ # packs per day ________
Approximate date of last Pap Smear _______ Result ________

FAMILY MEDICAL HISTORY

Has anyone in your immediate family had any of the following:

Heart Disease Y or N Family Member ________
High Blood Pressure Y or N Family Member ________
Varicose Veins Y or N Family Member ________
Cancer Y or N Family Member ________
Diabetes Y or N Family Member ________
Breast Tumors Y or N Family Member ________
Sickle Cell Anemia Y or N Family Member ________

PATIENTS PREGNANCY HISTORY

Have you had a positive pregnancy test Y or N Where & When ________
Total Number of Pregnanacies including this one ________
# of Children _______ What are there ages? _______ Did you deliver Naturally or have a C-Section? _______ if c-section why? ________
# of Miscarriages _______ When? _______ How many weeks were you? ________
# of Abortions _______ # of Stillbirths _______ # of Ectopic Pregnancies ________
Date of last pregnancy ________
### PATIENTS MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y or N</th>
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</thead>
<tbody>
<tr>
<td>Anemia</td>
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<td>Asthma</td>
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<td>Cancer</td>
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<td>Chest Pains</td>
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<td>Diabetes</td>
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<td>Epilepsy/Convulsions/Seizure Disorder</td>
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<td>Heart Disease/Murmur/Mitral Valve Prolapse</td>
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<td>Hemophilia</td>
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<td>Hepatitis (please list which one)</td>
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<tr>
<td>High Blood Pressure</td>
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<td>Hypoglycemia (low blood sugar)</td>
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<td>Kidney Disease/Stones</td>
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<td>Liver Disease</td>
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<tr>
<td>Pelvic Inflammatory Disease (PID)</td>
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<tr>
<td>Panic Attacks/Nervous Disorders/Depression</td>
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<td>Rheumatic Fever</td>
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<td>Shortness of Breath</td>
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<td>Thyroid Disease</td>
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<td>Tuberculosis</td>
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<td>Urinary Tract Infections</td>
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<td>Vaginal Infections/Yeast/Bacterial Vaginosis</td>
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<tr>
<td>Varicose Veins</td>
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<td>Venereal Disease</td>
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<tr>
<td>Sexually Transmitted Infections</td>
<td></td>
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<tr>
<td>Ever Been told not to take Birth Control</td>
<td></td>
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</tbody>
</table>
| Have you ever used any street drugs or are you using any now?  Y or N  If yes which kind?  
|                                                          |        |
| Have you ever been on pain medication for more than a week?  Y or N  If yes which kind and how long were you on it for  
|                                                          |        |
| Previous or Current Medical Problems                      |        |
|                                                          |        |
| Please state the type of service you desire today         |        |
|                                                          |        |
| How were you referred to A Woman’s World Medical Center? |        |

Patients Signature ____________________________ Date ___________
A Woman's World Medical Center, Inc.

Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida Law.

Patient Signature ________________________________

INFORMATION AND FACTS CONCERNING "TERMINATION OF PREGNANCY"

*NOTE: AFTER EACH PARAGRAPH PLEASE WRITE YOUR INITIALS. *

WHAT IT IS: A surgical procedure to terminate a pregnancy within sixteen (16) weeks from the last Day of your last normal period.

HOW IT IS DONE AT THIS FACILITY AND THROUGHOUT THE COUNTRY.

1. You will be examined by Dr. __________________ who is an OB/GYN. The doctor will determine the length of your pregnancy by a pelvic exam or ultrasound. __________

2. A speculum is inserted into the vagina for the cervix to be visible by the doctor. A local Anesthetic is injected into and around the cervix to numb this area. (cervix is the opening to the uterus) In some cases patients are given sedation to make them less nervous During the procedure. __________

3. The opening of the cervix is gradually opened by a series of narrow rods called dilators, Each a little thicker than the one before. You may or may not feel cramps during this process. The largest dilator may be as thick as a fountain pen, depending on how many weeks you are. __________

4. When the cervix is opened enough to admit a blunt tipped instrument called a cannula (straw Like in appearance) is inserted into the opening. The cannula is attached to the vacuum Aspiration machine, which is then turned on to empty the uterus. __________

5. After the uterus has been emptied by gentle suction, a small spoon shaped instrument called A curette is used to determine if the uterus is empty. __________

*NOTE: THIS PROCEDURE IN MOST CASES TAKES 3 TO 5 MINUTES.
POSSIBLE PROBLEMS AND COMPLICATIONS - As with any kind of surgery, complications can occur with early abortion. Early abortion by vacuum aspiration is, however, very safe. Fewer than 1 woman in 100 will have serious complication, including, but not limited to:

INFECTION - Infection is caused by germs from the vagina and cervix getting into the uterus. The risk of infection associated with early abortion is less than 1 in 100 cases. Such infections usually respond to antibiotics but, in some cases, a repeat vacuum aspiration or hospitalization is necessary.

HEMORRHAGE - Bleeding from the uterus heavy enough to require treatment occurs rarely. Bleeding heavy enough to require blood transfusion occurs less than 1 in 1,000 cases. Medication may be required to help the uterus contract, (go back to normal size) a repeat vacuum aspiration or dilation and curettage or rarely surgery may be necessary.

CERVICAL TEAR - The cervix is sometimes torn during the procedure. The frequency of this event is less than 1 in 100 cases. Stitches may be required to repair the cervix.

INCOMPLETE ABORTION - Occasionally, the contents of the uterus may not be completely emptied. The frequency of this event is less than 1 in 100 cases. This can lead to infection, hemorrhage, or both. To remove the tissue, it may be necessary to repeat vacuum aspiration or perform a dilation and curettage at the clinic or in the hospital. In rare instances, surgery may be required.

PERFORATION - Rarely, an instrument may go through the wall of the uterus. The frequency of this event is about 2 per 1,000 cases. Should this happen, hospitalization is required for observation and/or completion of the procedure. Perforation rarely requires surgery to repair the uterus. This can include hysterectomy (removal of the uterus), which makes it impossible to have children. The frequency of hysterectomy in this setting is about 1 in 10,000 cases. Very rarely does this occur.

FAILURE TO TERMINATE PREGNANCY - Rarely, does early termination fail to terminate a pregnancy. The likelihood of this event is about 2 per 1,000 cases. In such cases another suction is required.

DEATH - Early abortion is one of the safest procedures in medicine today. Information from the Center for Disease Control indicates that the risk of death from early abortion is about 1 in 100,000 cases. The risk of death associated with tonsillectomy is about 3 per 100,000 cases. The risk of death from childbirth is at least 7 times greater than termination.

ANESTHESIA REACTION - In some cases, local sedation can cause severe reactions or shock. Twilight might render the patient unconscious in a few patients. However in a small number of cases, severe complications which may result in injury, disability and very rarely death.

IMPACT OF ABORTION ON FUTURE PREGNANCIES - At this point, there is no clear evidence that one early abortion carries any risk to future pregnancies. Women have a slightly increased risk of premature birth or miscarriage after the third early abortion with future pregnancies. Some studies have shown this while others have not.
INFORMED CONSENT TO TERMINATE MY PREGNANCY. GIVE ANESTHESIA. PERFORM OTHER MEDICAL SERVICES AND AUTHORIZE RELEASE OF MEDICAL RECORDS IF NECESSARY.

I, _____________________________, Age _________, hereby give my consent to and request and authorize Dr. __________________________ and assistants of his/her choosing to perform an abortion on me. I understand that the purpose of an abortion is to end my pregnancy.

I understand the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure. I understand that the physician, medical personnel and other assistants will rely on statements I have made, the medical history I have given and other information in determining whether to perform the procedure or the course of treatment for me and I warrant that I have made a full, complete and truthful disclosure.

ADDITIONAL PROCEDURES If during the course of the abortion procedure, any unforeseen conditions or complications arise, and the doctor in his/her professional medical judgment decides that different or additional procedures including, but not limited to anesthesia or blood transfusion or the association of another doctor, or hospitalization at a hospital may be necessary, I give my permission for my parent (or legal guardian where applicable) or other person I name set forth on the next page to be notified by the doctor or staff member. The correct identity, and phone number of my emergency contact is on the next page.

LABORATORY I consent to diagnostic studies, tests, sonograms, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis of my condition or procedures set forth herein. I understand the purpose of a sonogram here is to determine gestational size only and NOT to rule out and determine fetal abnormalities and deformities. I also consent to the disposal of any tissue or other parts of contents of my uterus (womb) which may be removed during the abortion at the discretion of the physician of the clinic.

EMERGENCY If I develop a fever, heavy bleeding, severe cramping, pain or any other symptoms, I agree to notify the clinic at once. I have been given an emergency contact telephone number which I can call 24 hours a day for assistance. My failure to give notice releases the doctor and/or clinic from any responsibility to me.

FOLLOW-UP I have been advised to return to the clinic for a follow-up examination within 3 weeks after today. I understand that this exam is needed to be sure that no complications or other problems have appeared, that I am not still pregnant, and that the healing process has gone on properly. I agree to follow the instructions provided to me and take my medications as directed. I further agree to obtain the follow-up care either here or at some place else at my own expense. My failure to follow instructions or obtain care relieves the doctor and/or clinic of any responsibility to me.
I GIVE MY CONSENT FOR THE ABORTION FREELY AND WITHOUT COERCION By signing this form, I acknowledge that I have read or had this form explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information including but not limited to the materials listed below relating to the procedure described herein. I understand that I can request and receive a sample copy of this consent if I choose to do so.

ADDITIONAL MATERIALS USED OR FURNISHED TO PATIENT
Aftercare instructions with 24 hour emergency number, appointment card with follow-up time and date.
Antibiotics information and/or birth control pills or prescription/Depo Provera/Ortho Evra Patch prescription/Nuvaring prescription. Information sheet on how to continue Birth Control with follow-up care.

IN CASE OF EMERGENCY, PLEASE CONTACT

NAME: __________________________ PHONE: __________________________
Does the above person know you are here? Y or N  Relationship __________________________

Would you like to see your pregnancy tissue? Y or N

PATIENT SIGNATURE ______________________________ DATE ____________ COUNSELOR SIGNATURE ______________________________

PARENT SIGNATURE ______________________________ DATE ____________ WITNESS ______________________________
*****CONFIDENTIAL*****

All information on this form is held in the strictest confidence. We ask these questions so that we may better understand your unique situation and be better prepared to serve your individual needs.

NAME __________________________

How do you feel today about having your pregnancy terminated?

________________________________________________________________________

Do you have any fears about the termination? ________________

Do you have any doubts about your decision today to terminate your pregnancy?

________________________________________________________________________

What is your relationship with the man involved in this pregnancy?

________________________________________________________________________

*****************************************************************************

COUNSELOR NOTE'S

________________________________________________________________________

________________________________________________________________________

COUNSELOR SIGNATURE ___________  TODAYS DATE ________________
POST OPERATIVE CONTACT SHEET

Please fill out the following information as accurately as possible, in the event that we need to contact you after your abortion. We will contact you only if it is medically necessary. We will leave a message only as you indicate, as we take every precaution in maintaining your confidentiality and privacy concerning your visit with us. Please understand that it is for your protection that we require a telephone number and complete address. Thank you for your cooperation.

PLEASE PRINT

Full Name__________________________________________

Mailing Address

STREET _____________________________ CITY __________ STATE ______ ZIP ______

We will be contacting you about your follow up visit. Would you like us to email, phone or mail you? ____________________________

If Email what email address? ____________________________

Phone (_____)____________________________________ Best time to call ______ AM or PM

May we call you at work? Y or N Phone# __________________________

Okay to leave a message at work? Y or N With whom __________________________

Okay to identify A Woman's World? Y or N __________________________

Okay to leave a message at home? Y or N __________________________

Okay to say "Please have her call her dr.'s office? Y or N With whom __________________________

May we mail to your home address? Y or N __________________________

If no please give an address to which we may mail you information:

STREET _____________________________ CITY __________ STATE ______ ZIP ______

May we leave a message with a friend? Y or N __________________________

Friends Name____________________________________ Friends # __________________________

Do you have a nickname you go by __________________________

The above information is accurate and by filling out this form, I give permission for the above information to be used in post-operative contact of me, if necessary. I understand that all information given here about me is kept in strictest confidence.

PATIENT SIGNATURE ____________________________ DATE ________ REV 06/09
RU486 STATS

NAME:_________________________________________
AGE:_________________________________________
RACE:________________________________________
MARITAL STATUS:_________________________________
CITY:_________________________________________
REFERRED BY:___________________________________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
OFFICE USE ONLY

WEEKS:____________
PRIOR ABS:_________
RH TYPE:___________
DATE OF AB:__________