

RU486 STATS

NAME: _____

AGE: _____

RACE: _____

MARITAL STATUS: _____

CITY: _____

REFERRED BY: _____

~~~~~

OFFICE USE ONLY

WEEKS: \_\_\_\_\_

PRIOR ABS: \_\_\_\_\_

RH TYPE: \_\_\_\_\_

DATE OF AB: \_\_\_\_\_

**A Woman's World Medical Center, INC.  
503 S. 12th Street, Ft. Pierce, Florida**

Client Information for Informed Consent:  
Early Medical Abortion Using Mifepristone (RU486) and Misoprostol (Cytotec)

Before you have an abortion, be sure you understand the information we have given you. This fact sheet lists the benefits and the possible problems with having an early medical abortion using Mifepristone (RU486) and Misoprostol (Cytotec). If you have any questions as you read we will be happy to talk about them with you.

There are three options for women who become pregnant. These are #1 parenthood, #2 adoption, and #3 abortion. The other alternatives to medical abortion include Surgical Abortion, referral for an abortion under general anesthesia now or later in your pregnancy.

The term "medical abortion" is used for an abortion that is done using medications. A "surgical abortion" is one in which surgical instruments are used. The first trimester (the first three months of pregnancy), this is usually performed by vacuum aspiration, also called suction curettage (the pregnancy tissue is suctioned out of the uterus.) You have received from A Woman's World Medical Center, Inc. detailed written information about both medical and surgical abortion, the risks involved, and the possibility of complications. **You Should Not Begin A Medical Abortion Unless You Are Sure You Want To End Your Pregnancy, and you are willing to have a surgical abortion if the medical abortion fails.**

Early medical abortion must be done in the first eight weeks of pregnancy. An ultrasound will be done to determine the length of pregnancy.

You will be given two drugs. The first drug is **Mifepristone (RU486)**, which stops cells from dividing and growing. This drug has been approved by the Food and Drug Administration.

Since Mifepristone (RU486) only stops cells from growing, it does not usually result in abortion by itself. You will therefore be given a second drug, **Misoprostol** (Cytotec) that causes contractions (cramps) to expel the pregnancy, which is very much like a miscarriage. Misoprostol (Cytotec) has been approved by the FDA for use in the medical abortion.

You will be examined, and you will have some tests done. You will be given one pill of the first drug, Mifepristone (RU486), to stop the pregnancy from growing, and to start the abortion. 48 hours later you will take the second drug, Misoprostol (Cytotec), to start the contractions. These are pills that you will put between your cheek and gum - 2 pills on each side of your mouth. The whole abortion process is usually complete within 4 days after receiving the Mifepristone (RU486) or within 5-8 days after using the Misoprostol (Cytotec) pills, but it could take longer.

Before you get the Mifepristone (RU486) pill, you will have:

- \*\*\*\* A pregnancy test (from a blood or urine sample.)
- \*\*\*\* Some blood taken from your finger or arm to see if you are anemic (a "low blood count"), and to see if you are Rh Negative. If you are Rh Negative, you will get a shot of immune globulin:
- \*\*\*\* A vaginal ultrasound (a small wand is placed in the vagina to "look inside the uterus" to determine

length of pregnancy). Vaginal ultrasound works with sound waves - there is no radiation. You may need more than one ultrasound examination at A Woman's World Medical Center, INC.

\*\*\*\* A pelvic examination may be performed.

You will be given a pill of Mifepristone (RU486) by mouth. You will be given the Misoprostol (Cytotec) to take home with detailed instructions from the clinic staff about when to use it and how to use it buccally.

**About 50% of women will have the abortion the same day that the Misoprostol (Cytotec) pills are used, and another 35-40% will abort within a week. About 50% will need to take a second dose of Misoprostol (Cytotec). Since this type of abortion is about 90% effective, about 10% of women will not abort the pregnancy. If that happens, you will need to have a surgical abortion.**

Until you have a follow up examination and have been told that the abortion is complete, **You should not do the following:**

Do not take vitamins (they have folic acid in them) It can interfere with the Mifepristone (RU486).

Do not take aspirin, Excedrin or Motrin, it can cause increased bleeding.

Do not drink alcoholic beverages, it can cause increased bleeding.

The following will happen after you take the Misoprostol (Cytotec) pills:

Cramping. It can be mild or really strong, similar to having your period or early labor. This will probably start within one half hour to ten hours and can last until the tissue is passed. The cramping can be very strong and painful for several hours, but not usually for more than 48 hours. You will be given medicine to take for the pain.

Bleeding, that can be quite heavy and there may be blood clots (some large) for several hours. You may see the pregnancy tissue (usually small and white or gray in color) but may not see it as it may be inside a blood clot. The bleeding will be heavier than a normal period, possibly soaking a sanitary pad each hour. If the heavy bleeding lasts more than 12 hours, or you soak more than 2 maxi pads each hour for 2 hours in a row, you should call the telephone number provided by the clinician. Some bleeding may continue for up to 4 weeks and there may even be some irregular bleeding after that. It can vary from light spotting to heavy bleeding.

It is very important to return for check ups to be sure that the abortion is complete. The first follow-up visit may take place anytime you think you may have passed the tissue, to confirm that the abortion is complete, or if you want to check on your progress. At the follow-up visit (s):

Another ultrasound examination will be done.

If the abortion has not been completed, depending on the results of the ultrasound examination, you may just wait up to six weeks from the time you received the Mifepristone (RU486) to see if the tissue is passed.

## **Woman's World Medical Center, Inc.**

### **Medical Abortion Regimen Selection**

Once you have decided to have a medical abortion using Mifepristone (RU486) and Misoprostol (Cytotec), there are several options for the exact regimen you will follow. We are required by the government to give you two documents which outline the original FDA approved regimen. We also offer an alternative regimen, which has been shown in multiple research studies to be more effective, particularly at later gestations (after 7 weeks LMP).

The **FDA approved regimen** is about 95% effective in ending a pregnancy up to 49 days LMP. It is very safe. The details are as follows:

Day 1: 200 mg of Mifepristone (RU486) taken orally (by mouth) in the clinic.

Day 3: 400 mcg of Misoprostol (Cytotec) taken orally (by mouth) in the clinic. We require you to remain in the clinic up to four hours for observation, when you may expel the pregnancy and the lining of your uterus. Day 10-14: Follow up visit with exam and repeat ultrasound to confirm that the abortion is complete.

About 40% of all prescriptions are for what is known as "off-label" use of medicines. This means that doctors and scientists have discovered that medicines may have other uses besides what they were originally approved for by the Food & Drug Administration. These other uses which are published in major medical journals and have scientific evidence to support them are called "Evidence Based Medicine." This is the case with medical abortion. We now know that there is an increase in effectiveness and a decrease in some side effects if the second medicine, Misoprostol (Cytotec), is taken vaginally instead of orally. The number of pills also changes.

**The Evidence Based Alternative** regimen is about 97-98% effective in ending a pregnancy up to 56 days LMP. For women 57-63 days LMP it is about 95-96% effective. It is also very safe. The details are as follows:

Day 1: 200 mg of Mifepristone (RU486) taken orally. The blood stream can only absorb a certain amount of this medicine, and any extra is just flushed out of the body.

Day 3 (+ 48 hours): 800 mcg of Misoprostol (Cytotec) taken vaginally (inserted into your vagina) either at home or in the clinic. If you take the Misoprostol (Cytotec) in the clinic, you again need to stay for up to four hours of observation. We know that vaginal Misoprostol (Cytotec) provides a more gradual rate of medicine into your body that is sustained for a longer period of time, which may be why it is more effective than taking the medicine orally. We also know that there were less women who had problems with nausea and vomiting if they took the second medicine vaginally.

Day 10-14: Follow up visit with exam and repeat ultrasound to confirm that the abortion is complete.

Update as of 4/1/06 Misoprostol (Cytotec) is no longer being put in the vagina. We are telling patients to use Misoprostol (Cytotec) buccally which means between cheek and gum. 2 tablets on each side of your mouth. We also send Phenergan (anti-nausea) medication home with you.

In either case, if the abortion is not complete at the follow-up visit, you may take another dose of the second medicine, or you may just wait to see if your body finishes the abortion on its own. You may also request to have a surgical completion at any time in the medical abortion process, for whatever reason.

# A Woman'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.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
Rev/3/06

This will be provided at no additional charge if done at A Woman's World Medical Center.

\_\_\_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 sever 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 women'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 \_\_\_\_\_ W \_\_\_\_\_ please include area code

If you would like us to email you information and appointment reminders please leave your email address

**NOTE:** if you are a minor and live with your parents, are they aware of your visit here? Y or N  
Is there any other information we should have, in order to protect your confidentiality, in the event we may need to contact you? \_\_\_\_\_

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 pregnancy test Y or N Where \_\_\_\_\_

Number of Pregnancies including this one \_\_\_\_\_

Children \_\_\_\_\_ Miscarriages \_\_\_\_\_ Stillbirths \_\_\_\_\_ Abortions not including this one \_\_\_\_\_

Date of last pregnancy \_\_\_\_\_

## **PATIENTS MEDICAL HISTORY**

Have you ever had any of the following and when:

Anemia Y or N \_\_\_\_\_

|                                         |        |       |
|-----------------------------------------|--------|-------|
| Asthma                                  | Y or N | _____ |
| Cancer                                  | Y or N | _____ |
| Chest Pains                             | Y or N | _____ |
| Diabetes                                | Y or N | _____ |
| Epilepsy/Convulsions                    | Y or N | _____ |
| Heart Disease/Murmur                    | Y or N | _____ |
| Hemophiliac                             | Y or N | _____ |
| Hepatitis                               | Y or N | _____ |
| High Blood Pressure                     | Y or N | _____ |
| HIV                                     | Y or N | _____ |
| Hypoglycemia (low blood sugar)          | Y or N | _____ |
| Kidney Disease/Stones                   | Y or N | _____ |
| Liver Disease                           | Y or N | _____ |
| Pelvic Inflammatory Disease (PID)       | Y or N | _____ |
| Psychiatric Treatment/Nervous Disorders | Y or N | _____ |
| Rheumatic Fever                         | Y or N | _____ |
| Shortness of Breath                     | Y or N | _____ |
| Thyroid Disease                         | Y or N | _____ |
| Tuberculosis                            | Y or N | _____ |
| Urinary Tract Infections                | Y or N | _____ |
| Vaginal Infections                      | Y or N | _____ |
| Varicose Veins                          | Y or N | _____ |
| Venereal Disease                        | Y or N | _____ |

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? \_\_\_\_\_  
 \_\_\_\_\_

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 OBGYN. 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

A WOMAN'S WORLD MEDICAL CENTER, INC.  
503 SOUTH 12<sup>TH</sup> STREET  
FT. PIERCE, FLORIDA 34950

\*\*\*\*\*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 7/03