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NORTHLAND FAMILY PLANNING CENTERS/CLINICS

CONSENT FOR ABORTION, ANESTHETIC AND OTHER MEDICAL SERVICES, INCLUDING CONSENT FOR ADMINISTRATION OF ANESTHESIA

PLEASE COMPLETE THE FORM AND PROVIDE THE REQUESTED INFORMATION IN THE SPACES PROVIDED BELOW, BUT DO NOT SIGN UNTIL YOU HAVE MET WITH YOUR DOCTOR

I truly state that my name is _____ and that I am _____ years old, and was born on _____. I voluntarily agree to have an abortion performed upon me on or around _____, 20_____.

We are required to obtain your consent for your planned abortion surgery/medical procedure and anesthesia. What you are being asked to sign is confirmation that your doctor has discussed the nature, purpose, risks, benefits, and alternative treatment available in regard to your abortion surgery/medical procedure and anesthesia care. Except in cases of emergency, abortion surgery/medical procedures and anesthesia are not performed until you have the opportunity to receive this information and have given your consent. You have the right to consent to or to refuse any proposed abortion or medical procedure at any time prior to its performance.

You understand that the doctor who performs your abortion surgery/medical procedure and anesthesia is/are independent contractors and are not agents, servants or employees of Northland Family Planning Centers/ Clinics, Inc. (East and/or West, and/or South) ("the Facility"). Since they are independent contractors, the Facility is not responsible or liable for their acts or omissions.

You understand that the Facility maintains personnel and equipment to assist the doctor with abortion surgery/ medical procedures. You authorize the doctor to use additional associates i.e. physicians (who you understand are Independent Contractors), or other Facility staff including healthcare providers or workers necessary to assist the doctor with your abortion surgery/medical procedure and anesthesia.

By reading, initialing in the spaces provided herein, and signing this document, you agree to the following:

_____ 1. You understand the purpose of an abortion surgery is to end your pregnancy.

_____ 2. The decision to have an abortion and not have a baby at this time is your own personal decision, made without coercion or force. You understand you have choices—parenting, adoption, abortion—and you have thought over these choices before coming to the Facility. You have been given the opportunity at the Facility to discuss your choices and how you feel about them.

_____ 3. You are comfortable with your abortion decision and you agree that you are responsible for your own emotional health. You understand that your emotions may range from confidence and relief to significant distress, feelings of regret and/or depression. You understand that the staff at the Facility cannot predict how you will feel after your abortion. You have had an opportunity to fully discuss your feelings about this pregnancy and impending abortion. You have been advised to examine your own situation carefully to be sure you are emotionally ready before you have an abortion. You understand if you have any doubt you may cancel or reschedule your appointment and the Facility will provide you with additional resources and referrals.

_____ 4. You have told the truth about everything on all the forms you filled out, without exception, including your name, address, age and contact information. You understand that failure to give the requested information may affect your physical condition and could lead to potentially serious injuries or complications. If you have a complication resulting from false information or failing to give information which the licensed

physician/ practitioner relies upon in making medical decisions relating to your care and treatment, you release the Facility and their employees, officers and agents as well as the licensed physician/practitioner from any responsibility and liability for such complications.

_____ 5. You understand the type of ultrasound performed at the Facility is done to determine length of pregnancy ONLY, and that the ultrasound may range +/- two weeks. You understand the ultrasound today will not diagnose any other conditions, such as maternal or fetal abnormalities, ectopic pregnancy (pregnancy outside of the uterus), sex of the fetus, a very early pregnancy, etc. You understand that further testing may be required to determine pregnancy or to follow-up on any unexpected findings that suggest there might be a risk to my health. You also understand any additional testing, whether at the Facility or with another provider will be at your own expense.

_____ 6. You understand that abortion procedures and anesthesia may involve risks. You understand that the risks and complications associated with an abortion surgery/medical procedure and anesthesia are rare but complications, unsuccessful results, serious complications, injury, or even death, from both known and unknown causes, may occur, as in all surgical procedures and no warranty or guarantee of success has been made regarding results.

_____ 7. You understand the purpose of this informed consent is to ensure that your decision to have an abortion is made knowing the risks of this kind of procedure. The serious complications referred to are generally less likely to occur with abortion than with childbirth.

_____ 8. You understand it is impossible for the doctor to inform you of every possible complication that may occur. You have been informed that the possibility of complications include but are not limited to:

- Incomplete or missed abortion
- Perforation (tear) of the uterine wall and nearby organs
- Laceration of the cervix
- Uterine infection (there is an increased risk of uterine infection if the woman has a sexually transmitted disease or any other type of uterine infection)
- Hemorrhage (excessive bleeding)
- Rare allergic or adverse reaction to anesthetic or other medications which include fainting, shock, convulsions, cardiac arrest, brain damage, or death
- Rare possibility of death
- Internal injuries or injury to the bowel or bladder
- In rare, but possible situations, permanent disability and/or permanent (hysterectomy) sterility may result
- If you have a multiple pregnancy or Previous C-section(s) or previous injuy to the cervix or reproductive organs, the chance of complication increases

_____ 9. You understand that serious problems are rare and that the Facility can care for almost any problem you may have in the Facility, quickly and without further cost. You understand that if treatment is needed elsewhere or if you seek treatment on your own, you are responsible for all the expense incurred. Any fees that have been paid to the Facility will not be refunded. Complications may be treated by a repeat suction, additional medications, hospitalizations, blood transfusion, and/or additional surgery.

_____ 10. You understand and agree that in the event any complication arises from your abortion procedure and hospitalization is required, your insurance company will be billed. You further understand that if you have no active health insurance or insufficient coverage with your existing policy at the time of your abortion procedure, you are solely responsible for any and all expenses that may arise from complications that are treated outside the Facility. You further agree to pay these expenses when billed.

_____ 11. An ectopic pregnancy is a preexisting medical condition and is **NOT** a complication of abortion. **An ectopic pregnancy is life threatening and needs immediate follow-up.**

_____ 12. You understand that because abortion is a “blind” procedure (the physician cannot see into your uterus), there is the possibility of bleeding which builds up or cannot get out of the uterus. There is the possibility of an incomplete abortion (part of the pregnancy tissue remains in the uterus) or the pregnancy can be missed in the abortion procedure and you could still be pregnant. You understand that all of these require a repeat of the abortion procedure (no charge at the Facility) and you consent now to such treatment. If you later refuse such treatment, you assume all risks and release (The Facility) from any further responsibility for your care or the outcome of your decision. Any fees you have paid to the Facility will not be refunded.

_____ 13. If an unforeseen condition or complication arises during the abortion and, in accordance with good medical practice, calls for a different or additional treatment, you give the physician permission to do whatever in his or her professional judgment is necessary. Examples of such treatment are: the administration of I.V. fluids, the use of ultrasound during the abortion, repair/suturing of cervical tear and/or hospital admission and blood transfusion.

_____ 14. You understand that in the event a complication occurs that requires hospitalization, the Facility cannot be held responsible for any breach in confidentiality. If you are a minor, it may be necessary to notify your parents or legal guardian in order to get consent for hospitalization; this overrides even the Judicial Bypass.

_____ 15. You consent to your physician and their assistant giving you such anesthesia or pain relievers as may be advisable or necessary with the exception of _____ (you must write “none” if there is no exception). The Facility offers many options of analgesia and anesthesia to decrease discomfort during an abortion. Options include: local anesthesia, light and moderate IV sedation. **Local anesthesia**: an injection given into the cervix just before the abortion. Benefits: decrease discomfort caused by dilation. Risks: failure to relieve discomfort, severe allergic reaction, seizures, cardiovascular and respiratory compromise, arrest, death. Side effects: discomfort on administration, ringing in ears, metallic taste in mouth, dizziness, racing heart. **Light and Moderate sedation:** IV medication given just before the abortion. Benefits: decreased discomfort and awareness during the abortion. Risks: failure to decrease discomfort and awareness during the abortion, severe allergic reaction, phlebitis (inflammation of a vein), prolonged unconsciousness, seizure, cardiovascular and respiratory compromise, arrest, unanticipated depth of sedation, stroke, death. Side effects: drowsiness, dizziness, amnesia, decreased coordination and mental function, decrease in inhibitions, nausea, vomiting, discomfort during injection. You understand the benefits, risks and side effects of the medications being used.

_____ 16. You understand that if you choose any of the optional IV sedations, you cannot drive, operate heavy machinery or make any important decisions requiring a judgment call for 24 hours.

_____ 17. You give your consent to medical tests that the physician feels are appropriate or necessary. You understand that tissue and/or fetal parts will be removed during the abortion and you give your permission for them to be disposed of according to the law.

_____ 18. If a physician, other health professional or employee is exposed to your blood or bodily fluid, you consent to having your blood drawn for tests including, but not limited to, HIV and Hepatitis. If your tests are positive, you will be informed. The results of any test(s) will be treated confidentially, but may be disclosed as necessary to the Facility personnel that render care and services to you.

_____ 19. You understand that it is your responsibility to bring to the attention of the Facility any post-abortion problems you may encounter, which could include fever, heavy bleeding, severe cramping or pain, unusual or foul smelling discharge, or the absence of a period within eight (8) weeks of the procedure. You agree to direct any post-abortion questions to the staff of the Facility. You understand that it is ill-advised to accept advice from individuals who are not directly involved with the abortion and that follow-up treatment by anyone not familiar with abortion practice and complications is not advisable. You realize that should such problems arise, immediate treatment may be necessary to avoid more severe complications. Your failure to give notice within a reasonable time and/or refusal to follow medical recommendations or treatment releases the Facility and the licensed physician/practitioner from any further responsibilities to you.

_____ 20. You understand your failure to bring any post-abortion problems to the attention of the Facility and/or your refusal to follow medical advice, releases the Facility of any further responsibilities for you, and if treatment is needed elsewhere or you seek treatment on your own, you are responsible for all the expenses incurred. Any fees that you have paid the Facility will not be refunded. You also understand that if you are having a post-abortion related problem, there is no office visit charge until you are released from care.

_____ 21. You understand that your next period should be 4-8 weeks after your abortion. If you do not start your menstrual period 8 weeks after the abortion, you agree to contact the Facility and arrange an appointment for an examination immediately.

_____ 22. Please circle “Yes” if you would like to view your pregnancy **after** your abortion: YES.

_____ 23. You acknowledge receipt of the Home Care Instruction booklet, which includes the phone numbers of all NFP Clinics/Centers and the after-hours answering service number. You understand you can call the after-hours number directly and that a physician is on call 24 hours a day, 7 days a week for emergencies. You agree to follow all Home Care Instructions.

_____ 24. If you choose to take birth control pills or use the vaginal ring: You understand that the possible side effects include severe abdominal pain, chest pain and leg pain (especially in the calves), headaches or blackouts, loss of vision on one or both eyes, blurred vision, blood clots and stroke. You agree to report any and all medical side effects to the Facility immediately.

_____ 25. In the event one or more of the provisions contained in this Agreement shall, for any reason, be deemed null, void, or inoperative for any reason, the provisions are severable and any remaining provisions shall remain in full force.

_____ 26. If you are treated after the abortion by anyone other than the licensed physician/practitioner who treated you at the Facility, you _____ (SS#_____, DOB_____) authorize such other providers of such other services to release your entire medical record to Northland Family Planning Centers/Clinics. You have read and understand the Facility's HIPAA policy and have signed their patient privacy notice. You agree to and authorize the Facility to obtain any and all medical records for care that may be related to the abortion even though this release is signed prior to your receiving such services. You approve using a photocopy of this release to obtain such records. If you choose to be treated after the abortion by anyone else you release the Facility and the licensed physician/practitioner from any liability for your health care.

Your signature below certifies (1) that YOU have read (or have had read to you) and understood the information provided in this form; (2) that the surgery/medical procedure and anesthesia noted above has been adequately explained to you; (3) that you have had the chance to ask questions and your questions have been answered to your satisfaction; (4) that you have received all of the information you need concerning the abortion surgery/medical procedure and anesthesia; (5) that you accept the risks of the procedure; (6) that you authorize and consent to the performance of the surgery/medical procedure and anesthesia.

_____	_____	_____	_____
Patient Signature	Date	Physician Signature	Date
_____	_____	_____	_____
Translator Signature	Date	Witness Signature	Date
_____	_____		
Parent/Guardian Signature	Date		

_____	_____	_____
Return Date	Pt Initials	Physician Signature