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PATIENT CONSENT FOR MEDICATION ABORTION

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, _____, am _____ years old. I am requesting that my pregnancy be ended by a medication abortion using mifepristone in combination with misoprostol on or about _____, 20____.

We are required to obtain your consent for your planned abortion procedure. You are being asked to confirm by signature that your doctor has discussed the nature, purpose, risks, benefits, and alternative treatment available in regard to your abortion procedure care. Except in cases of emergency, medical procedures 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 providing your medication abortion care is/are independent contractors and are not agents, servant, or employees of Northland Family Planning Centers/Clinics (East and/or West, and/or South) . Since they are independent contractors, Northland Family Planning is not responsible or liable for their acts or omissions.

Medication abortion treatment:

1. You understand that a medication abortion is the use of medications to end a pregnancy. You understand that a medication abortion is a self-managed abortion. This is an induced miscarriage in which you are managing your care at home. We cannot predict a timeline in which this will happen.

2. You live within 1 hour of a Northland Family Planning center (NFP) Y / N (circle one). If no, You live within 1 hour of a hospital Y / N (circle one). If yes, Name of Hospital_____
Pt initials_____

Side effects of medication abortion / medication:

3. You understand that misoprostol causes contractions and uterine bleeding which will eventually expel the pregnancy. Possible side effects may include: nausea, vomiting, diarrhea, abdominal pain, flatulence, dyspepsia (indigestion or heartburn) and headache.

4. You state that you do NOT have any of the following conditions, which are contraindications to misoprostol: Allergy to prostaglandins; Inflammatory bowel disease, such as Colitis, Crohns disease or a medical condition that requires me to take “blood thinners” i.e. Aspirin, Coumadin (Warfarin) or Heparin.

Risks of a medication abortion:

5. You understand it is impossible for the doctor to inform you of every possible complication that may occur. You understand that there are possible health risks involved with the medication abortion and the possible consequences of these risks have been explained to me. These risks include, but are not limited to, failed medication abortion, incomplete medication abortion, fever, infection, transfusion or death. Although bleeding and cramping are an expected part of ending a pregnancy, rarely, serious and potentially life-threatening bleeding, infection, or other problems can occur following a miscarriage, surgical abortion, mediation abortion or childbirth.

6. You understand that you may pass the pregnancy at any time or place. You also understand that you may see blood clots and the products of your pregnancy.

7. You understand that if all of the pregnancy tissue is not expelled, the risk of infection in your uterus may increase.

8. You have been told that medication abortion using mifepristone and misoprostol has a 3-5% failure rate, and that each medication used could cause birth defects if a pregnancy were to continue after you take them.

9. Should there be heavy bleeding or severe pain; a surgical abortion may be needed. You understand that this occurs in about 1 out of 100 people and failure to have a surgical abortion under these circumstances could result in serious harm. You understand that you can request a copy of the surgical abortion consent from prior to starting the medication abortion process so you are fully aware of the risks of the surgical option before you proceed.

10. You acknowledge that no guarantee has been made to you regarding the result of this medication abortion. You understand and agree that if you choose NOT to return to NFP, and seek to complete your abortion at any place other than NFP, you do so at your own expense. Any fees you have paid to NFP will NOT be refunded. You may also be billed for any remaining fees due.

11. You understand that serious problems are rare and that NFP can care for almost any problem you may have quickly and without further cost, however, unforeseen complications may arise, which could require additional treatment or hospitalization at your own expense.

12. You understand that the physician and staff will rely upon statements that you make to determine if you are eligible for a medication abortion procedure. You have disclosed your full medical, surgical and psychiatric history, a complete list of medications, supplements and/or vitamins you take or have recently taken and any hospitalizations or visits to the emergency department; realizing that a failure to do so would be harmful to your health. You have made a full, complete and truthful disclaimer of all such information. You understand that if you withhold or falsify information that might affect your medical care, the physician and NFP staff cannot accept responsibility for any problems that may result.

Alternatives:

13. You have made this decision because you do not want to have a baby at this time. You know that your other choices are parenthood, adoption and surgical abortion, but medication abortion using mifepristone and misoprostol is your personal choice. No one is forcing you to choose abortion; it is your own decision.

Exam, ultrasound and/or testing

14. You agree to a pelvic exam and/or a vaginal and/or abdominal ultrasound in order to accurately date your pregnancy.

15. You understand the type of ultrasound performed at Northland Family Planning is done to determine length of pregnancy ONLY, and that it may range +/- two weeks. You understand that the ultrasound today will not diagnose other conditions, such as maternal or fetal abnormalities, ectopic pregnancy (pregnancy outside the uterus), gender 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 your health. You also understand that any additional testing, whether at Northland Family Planning or with another provider will be at your own expense.

Follow up Care

16. You agree to do the following:

- Contact your provider right away if in the days after treatment you have a fever of 100.4º F or higher that lasts for more than 4 hours or severe abdominal pain.
- Contact your provider right away if you have heavy bleeding (soaking through two thick full-size sanitary pads per hour for two consecutive hours).
- Contact your provider right away if you have abdominal pain or discomfort, or you are “feeling sick,” including weakness, nausea, vomiting or diarrhea with or without fever, more than 24 hours after taking misoprostol.
- Take the MEDICATION GUIDE with you if you visit an emergency room or a provider who did not give me mifepristone , so they understand that you are having a medication abortion with mifepristone .

17. 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.

18. You agree to speak with your provider about a surgical procedure to end your pregnancy if the medication abortion is unsuccessful, as each medication used could cause birth defects if a pregnancy were to continue after you take them.

19. You understand that your medical provider must be able to contact you during your treatment if necessary. Every attempt will be made to follow your instructions as to the best times to call and what messages to leave to assure your privacy. You also understand that all information in your medical records will be kept confidential, but that information gathered from your records, without your name or other identifying markers, may be analyzed.

Release:

_____My initials here indicate that I have read through #1-19 above. I agree to ask any questions that I might have to my Patient Advocate.

Consent for records release:

If you are treated after the abortion by anyone other than NFP, you, _____ SS#_____DOB_____ authorize such other providers of such other services to release your entire medical record to Northland Family Planning Center. You have read and understand NFP's HIPAA policy and have signed their patient privacy notice. You agree to and authorize NFP to obtain any and all medical records for care that may be related to the abortion, even though this release is signed prior to my 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 rather than return to NFP, you release NFP et al from any liability for your health care.

Your signature below certifies (1) YOU have read (or have had read to you) and understood the information provided on this form; (2) that the medication procedure 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 accept the risk of the procedure; (5) that you authorize and consent to the medication abortion procedure.

_____ _____ _____ _____

Patient Signature Date Physician Signature Date

_____ _____ _____ _____

Parent or Guardian Signature Date Witness Signature Date

_____ _____

Translator Signature Date

_____ _____ _____

Return Date Pt. Initials Physician Signature