Cherry Hill Women's Center
CONSENT TO ABORTION
(TERMINATION OF PREGNANCY)

Patient Name: _____ DOB: _____ Date: _____

I, _____ consent and authorize Dr. and assistants of his/her choosing to perform an abortion to end my pregnancy. My consent to this abortion is both voluntary and informed.

ABORTION PROCEDURE: I understand that an abortion is a procedure performed to end a pregnancy. I understand how my abortion will be performed and understand the procedures that are likely to be used. I understand that there are possible health risks associated with an abortion and I understand the possible consequences of these risks. I also understand that I may experience side effects from the abortion procedure.

SIDE EFFECTS OF ABORTION: The side effects that I may experience include but are not limited to: Nausea, vomiting, bleeding, cramping and pain.

RISKS OF ABORTION: The possible health risks involved with this abortion and the possible consequences of these risks have been explained to me. I understand that these risks include but are not limited to: fever, infection, hemorrhage, embolism, disseminated intravascular coagulation (DIC), cervical incompetency, rupture of the uterus, shock, cardiac arrest, perforation of the uterus and/or bowel and death.

While it is rare for women to experience depression or severe distress after an abortion, I understand it may occur. I understand that I may call the 24 hour emergency number at any time. I also understand that follow-up counseling and counseling referrals are always available.

I understand that in certain instances a repeat abortion or additional treatment may be needed to end my pregnancy. The following are examples of when I may need an additional procedure or further treatment to end my pregnancy or pregnancies.

INCOMPLETE ABORTION: In some instances, all of the pregnancy tissue may not be removed from the uterus and the abortion will be incomplete. If this occurs, the abortion procedure may have to be repeated.
MULTIPLE PREGNANCIES: In the event of a multiple pregnancy, another abortion procedure may be required.
ECTOPIC PREGNANCY: In some instances, the pregnancy might occur in the fallopian tubes leading to the uterus. This is called an ectopic pregnancy. An abortion procedure cannot successfully terminate an ectopic pregnancy and I will need to be hospitalized to treat this condition.
HETEROTOPIC PREGNANCY: In rare instances, women may have a pregnancy in the uterus and in the fallopian tubes. This is called a heterotopic pregnancy. I have been informed that a heterotopic pregnancy may not be diagnosed on the day of my abortion. In the rare event that I have a heterotopic pregnancy, I will require hospital treatment and may require emergency surgery.

I understand and accept the risks outlined above. I also acknowledge that although my physician has made every effort to anticipate problems I may have during the abortion procedure, certain complications cannot be predicted. In the event that a complication does occur during my abortion, I understand that I may need to be hospitalized, may require a blood transfusion and may need additional surgery. I understand that I may require a hysterectomy, the surgical removal of my uterus, which would mean I could not get pregnant again.

I also understand that in rare occurrences death can occur related to an abortion procedure. The risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks to one per 29,000 at 16–20 weeks—and one per 11,000 at 21 or more weeks.

ALTERNATIVES: I understand that the alternatives to abortion are to carry this pregnancy to term, have a child and parent or carry to term and make an adoption plan. I have considered these alternatives and the staff have offered to make referrals to appropriate agencies for pre-natal care and adoption. I decline these alternatives and request that the abortion procedure be performed to end my pregnancy.

RISKS OF ANESTHESIA: I understand that to eliminate, control or reduce pain it may be advisable for me to receive anesthesia during a surgical abortion. I consent to and authorize the use of anesthesia, as my doctor may deem appropriate. I understand that "local" anesthesia does not always eliminate pain and that in a small number of patients, it can cause severe physical reactions or shock. I have also been advised that "general" anesthesia will render me unconscious and may cause bodily reactions or serious complications requiring additional measures and treatments. I also understand the need for anesthesia may increase if the abortion is more complicated than expected. I understand that if I receive general anesthesia, I will not be allowed to leave Cherry Hill Women's Center on my own, nor will I be capable of making any important decisions, operating a vehicle, or caring for small children for 24 hours following anesthesia.

I have been informed of the kind of anesthesia that will likely be used during the abortion. I know that risks and complications are possible when anesthesia is used. These risks include but are not limited to: soreness in my jaw, damage to teeth and mouth, injury to vocal cords and airway, convulsions, phlebitis, respiratory failure, cardiac arrest, prolonged unconsciousness and even death. I accept the potential risks and specifically consent to the use of one or more kinds of anesthesia as my doctor deems appropriate. I understand that my doctor may decide that I am not a candidate for anesthesia and/or may be unwilling to perform my procedure if I have ingested anything past midnight the night before the abortion.

LABORATORY: I further consent to and authorize the Cherry Hill Women's Center employees to perform all necessary diagnostic tests, studies, sonograms, and procedures that may be required to monitor my health prior to, during and after the abortion. I understand the purpose of ultrasound testing is for the determination of gestational age only and not for the detection of abnormalities, defects, or fetal sex. I further consent to blood tests that will determine my hemoglobin and Rh factor. I consent to the disposal of any tissue or other parts of the contents of my uterus which may be removed during the abortion. I understand that all tissue is sent to an outside laboratory for a microscopic exam performed by a Pathologist. I agree that the clinic staff may need to contact me by phone regarding additional laboratory findings and I consent to receive phone calls to inform me of the results. If I fail to respond to the phone call, a certified letter will be sent to the address on record, urging me to seek medical care. I understand my confidentiality will be respected where possible.

FOLLOW-UP CARE: I understand that the Cherry Hill Women's Center offers a post-operative check-up at no additional cost. I understand that the purpose of the check-up is to evaluate how I am feeling emotionally and physically and to discuss birth control. If I feel the need for treatment prior to my post-operative checkup, I will immediately contact the Cherry Hill Women's Center. I confirm that I have been given instructions about medications and follow-up care and have been offered a follow up appointment at the Cherry Hill Women's Center. If I choose not to return to the Cherry Hill Women's Center, I agree to have a post-operative check-up at another facility. If I choose to go to another facility, that visit will be at my own financial expense. I acknowledge that my failure to follow these instructions will relieve the Cherry Hill Women's Center from any further responsibility to me. I further agree that the Cherry Hill Women's Center will not be responsible for any expenses that I may incur for follow-up care and treatment after the abortion and I will bear sole responsibility for all such costs and expenses.

RELEASE: By signing this form, I acknowledge that I have read it or had it read to me. I fully understand the contents of this form. I also understand that without my full consent, my physician will be unable to perform the abortion. I understand that the physician and the Cherry Hill Women's Center staff will rely upon statements that I make to determine if I am eligible for an abortion procedure. I have disclosed my full medical, surgical and psychiatric history, a complete list of medications I take or have recently taken and any recent hospitalizations or visits to the emergency department. I have made a full, complete and truthful disclaimer of all such information. I understand that if I withhold or falsify information that might affect my medical care, the physician and Cherry Hill Women's Center staff cannot accept responsibility for any problems that may result. I have attended and completed a counseling session at which the risks, complications of and alternatives to the abortion procedure have been explained to me in detail. I have been given full opportunity to ask any questions and my questions have been answered to my satisfaction.

I hereby request and authorize the Cherry Hill Women's Center to proceed with the abortion procedure to end my pregnancy.

Patient's Signature: _____ Date: _____ Time: _____

Counselor's Signature: _____ Date: _____ Time: _____

Physician's Signature: _____ Date: _____ Time: _____

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