GORLI HARISH, MD
KANAWHA SURGICENTER., 4803 MacCorkle Ave. SE. Charleston, W.V. 25304
Phone: (304) 925-6390 Fax: (304)-925-7931

Patient Name:______________________________________Age:_________Appt Date:____________Time_________

1. Dr. Gorli Harish is a Physician licensed by the State of West Virginia and will be performing your Abortion procedure.

2. According to the information provided by you, you are approximately___weeks. However, on the day of your appointment an ultrasound will confirm the gestation.

3. The Medical Risks associated with carrying the pregnancy to term:
   A. The risk of death and/or major health problems of the mother are twenty times greater, then associated with having a pregnancy terminated in the first twelve weeks.
   B. Premature delivery and/or birth defects.
   C. Postpartum depression and psychological problems associated with hormonal changes.
   D. Uterine rupture.
   E. Toxemia of pregnancy.
   F. Hysterectomy (Surgical removal of uterus and/or ovary and tubes)
   G. Infection(Post vaginal or c-section delivery)
   H. Excessive Bleeding.
   I. Stroke
   J. Urinary and/or fecal incontinence
   K. Permanent alterations in body shape and appearance.
   L. Increased cost of child raising and childcare.
   M. Extreme pain associated with labor and delivery.
   N. C-section (Surgical delivery of term pregnancy).
   O. High Blood Pressure.
   P. Diabetes.
   Q. Death.

DO YOU UNDERSTAND THESE RISKS THAT I HAVE INDICATED? Yes___ NO___

4. The following are medical risks associated with the method of termination used by this facility (vacuum aspiration):

   A. Allergic reactions to pr-operative medications (seizure, asthma, etc)
   B. Uterine perforation (rare less than 2 per 1000)
   C. Cervical Lacerations (rare)
   D. Excessive Bleeding
   E. Retained products of conception
   F. Infection
   G. Inability to terminate the pregnancy
   H. Possibility of exploratory surgery
   I. Psychological problems post procedure (depression, grief, etc.)
   J. Discomfort/Pain associated with cramping-usually mild
   K. Death (it is much safer to terminate a pregnancy than to remain pregnant)?

DO YOU UNDERSTAND THESE RISKS AS I HAVE INDICATED? YES ___ NO___

5. Do you wish to discuss adoption alternatives? **YES ___ NO___**
6. Do you understand that the father of the child must provide financial assistance if you deliver the pregnancy? **YES___ NO___**
7. Do you wish to discuss assistance programs available in the State of West Virginia? **YES___ NO___**
8. Do you wish to review statistical material provided by the State of West Virginia before having your abortion (This material may be obtained by calling the Department of Health at 304-558-8870) **YES___ NO___**
9. Do you wish to review material provided by the Physician showing an anatomical and physiological characteristics of the embryo or fetus at 2-weeks to full term? **YES NO**
10. Do you wish to review the printed materials that are available on the State Sponsored Website at: ***WWW.WVDHHR.ORG. YES___NO_____***

DO YOU WISH TO REVIEW MATERIAL PROVIDED BY THE WEST VIRGINIA STATE LAW, SENATE BILL 170 OR "THE WOMEN'S RIGHT TO KNOW ACT OF 2003"?

I ACCEPT_________ I REFUSE_________ _________________________________ _____________

(PT INITIALS) (PT INITIALS) (PATIENT SIGNATURE) (DATE)

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PATIENT

_________________________I received all the information above at the least one day prior to the scheduled date of my procedure and have no further questions regarding this information at this time.

________________________I understand that the decision to terminate or continue my pregnancy is one of which only I can decide and that I have a legal right to do so. Having made this decision of my own free will, II elect to terminate my pregnancy.

____

PATIENT SIGNATURE DATE

PATIENT CERTIFICATION FOR ULTRASOUND
In compliance with WV senate bill 597

I certify that I have read and understand the following:

1. **It is my right to view or decline to view the ultrasound image, if an ultrasound is performed in conjunction with the performance of an abortion procedure;**

I also certify that:

1. **At least 24 hours before the abortion procedure, I was informed that prior to the abortion I would be presented with a form that I would be required to sign prior to the abortion procedure, and that the form would inform me of my opportunity to view the ultrasound image and my right to view or decline to view the ultrasound image.**
2. **Prior to the abortion, I was informed of my opportunity to view the ultrasound image developed in conjunction with my abortion procedure and of my right to view or decline to view the ultrasound image.**

My decision was as follows:

______ I choose not to view the ultrasound image.

______I choose to view the ultrasound image.

I have read and signed this certification form prior to the performance or inducement of the abortion.

Patient Name Printed_______________________________________

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PATIENT SIGNATURE DATE

I, GORLI HARISH, MD have confirmed with (patient)___________________that the above information was provided at least one day prior to the scheduled date of the procedure.

______________________________ ________________________

GORLI HARISH MD ***DATE***

_________________________ __________________________________

EMPLOYEE SIGNATURE **(PRINT)** ***EMPLOYEE NAME (PRINT)***