PLANNED PARENTHOOD® LEAGU
Boston Worcester Spri

Last: RAPER
First: JENNIFER
DOB: 05/17/61 Age: 42
Chart #:10140698
DOS: 04/09/04

Recovery Record

Name _____ DOB _____ Chart # _____ Date _____

Time admitted 9 _____ Station 2

Vital Signs

Time	BP	P	RR	SAO_2	Bleeding			Cramps		
admission	110/80	88	16		light	moderate	heavy	mild	moderate	severe
					light	moderate	heavy	mild	moderate	severe
					light	moderate	heavy	mild	moderate	severe

For patients with asthma: monitor for 30 minutes.

Medication	Dose	Route	Time	Nurse
Doxycycline	200 mg	po	1001	[signature]
Ibuprofen	600/800 mg	po (if none pre-op)		Teresa Roberts, RN
Acetaminophen	1000 mg	po (if none pre-op)		
Methergine	0.2 mg	po *or* IM Site		
Depo Provera	150 mg	IM Site (2) arm	10 am	[signature]
Lunelle	0.5 cc	IM Site		Pamela Longtin, RN
Rhogam ☐ Mini dose	☐ Full dose	IM Site		
Atropine	____ mg	IVP		
β-antagonist	ii puffs	inhaled		

IV Fluids

#1 D5LR 500 cc started at _____
#2 D5LR 500 cc started at _____
Total fluid absorbed _____

Nurse's Notes:
DEPO LOT #
KE0093

Nurse signature _____

Discharge

☑ Plan B ii po stat Refills #3
☑ 1 cycle DMPA 28 given
☐ Other Rx given
☐ Methergine 0.2 mg TID x 3d: Rx given
☐ F/C given

Time 1020a BP 120/60 P 88 RR 18
Bleeding (light / moderate / heavy) Cramps (mild / moderate / severe)
General condition: ☑ Stable ☑ Ambulatory ☐ Other: _____ IV D/C'd Time: _____ ☑ N/A
☐ Has a ride home ☑ N/A drive self
☑ Post-op instructions reviewed and discharge completed. Time discharged: 1022am
Staff signature [signature] RN
Teresa Roberts, RN

Post-Op Appointment

☐ Planned Parenthood ☑ Own Provider _____ ☐ Referral letter received

I have received verbal and written post-operative instructions and emergency information.
Patient signature Jennifer Raper

Rh Negative Label
☐ Rh positive

Allergy Label
☐ NKDA
☐ No latex allergy

AB 02
PPLM 2/04

PLANNED PARENTHOOD® LEAGUE OF MASSACHUSETTS, INC.
Boston Worcester Springfield

Abortion Service Medical Report
4.0 - 12.6 weeks

CHART # Last: RAPER
First: JENNIFER
DATE ___ DOB: 05/17/61 Age: 42
Name ___ Chart #:10140698
DOS: 04/09/04

LMP ___ GA ___ GA by U/S 6w.3d
G 9 P 4 A 3 M 1 C-Sec 1 Ectopic ___
Special Problems/concerns ___ ☐ 1st pelvic
BC method desired Depo
IVCS Eligible? ☒ NPO x ___ hours ☐ has ride ☒ ineligible
Interviewer signature [signature]

Lab
Temp 98.5 Pulse 72 R/R 16 B/P 112/84
Height 5'8 1/2" Weight 220 Hgb 13.2 Rh positive
sensitive urine preg test (if indicated) ___

Screening desired? ☐ Chlamydia ☐ GC ☐ Pap ☐ N/A
☒ Chart reviewed Linda Howard RN (RN)
Linda Howard, R.N.

FOR IVCS ONLY
Lung Exam (if history of asthma)
☒ lungs CTA, no wheezing ☒ Pt eligible for IVCS
☒ B-antagonist inhaler 1 puff ASAP
☒ pt eligible for IVCS ___ (MD)

Nurses Notes
___ Butterfly placed in ___ at ___
___ Angio placed in ___ at ___
___ mcg Fentanyl given IV at ___ and/or
___ mg Versed given IV at ___
___ mg Atropine given IV at ___
other meds given ___ at ___

Vital Signs
Time ___ BP ___ Pulse ___ R/R ___ SAO2 ___ LOC ___
___ ___ ___ ___
___ ___ ___ ___
___ ___ ___ ___
LOC 2 awake 1 arousable 0 non responding
Notes ___

Nurse signature ___ (RN)

Assistant [signature]

Rh Negative Label
☒ Rh positive

Allergy Label
☒ NKDA
☒ No latex allergy

Pre-op orders:
☒ Ibuprofen 600 / 800 mg po Time 9:25 a Initials [illegible]
☐ Ativan 1.0 / 0.5 mg po / sl Time ___ Initials ___
IV Sedation
☐ Fentanyl 50 mcg IV push. May repeat up to 100 mcg.
☐ Versed 1 mg IV push. May repeat up to 2 mg.

Exam
ext. genitalia: ☒ nl ___
uterus size: 6 wks ☐ ? Fibroid ___
position: ☒ mid ☐ AV ☐ RV
vagina: ☒ no discharge ___
cervix: ☒ nl ☐ CMT ___
adnexa: ☒ nl ☐ tenderness ___ ☐ mass ___

Abortion Procedure
Start: 9:25 a Finish: 9:40 a
6 point paracervical block with Buffered 1% Lidocaine
20 cc total with ___ u vasopressin ___ mg atropine
___ other ___
Cervix dilated to 19 # Pratt ☐ manual
6 suction tip used ☐ sharp curette used
Estimated blood loss: <50 cc
☐ Uncomplicated
☒ Complicated ☐ U/S guidance for difficult procedure
☒ U/S for incomplete tissue
☐ Re-evac

Gross Tissue Exam
☒ decidua ☒ villi ☒ sac ☐ placenta ☐ fetal parts
Evaluation of products of conception: 6 wks
☐ Tissue examined with staff person
☐ Post-op ultrasound: ☐ No retained tissue
☐ Other ___
☐ High alert protocol: ☐ Tissue sent for micro
☐ BSU
☐ Ectopic precautions

☐ Chlam ☐ GC ☐ Pap

Post-op orders:
☐ Doxycycline 200 mg po after procedure
☒ Plan B ii po stat Refills #3
☐ Methergine 0.2 mg po TIDx3 ☐ Methergine 0.2 mg IC/IM ASAP.
☐ MicRhogam
☐ Other ___

Contraceptive RX:
☐ Tricyclen-Lo ☐ Mircette
☐ Cyclessa ☐ Nordette
☐ NuvaRing ☐ Orthocyclen
☐ Ortho Evra ☐ Demulen 1/35
☒ DMPA ☐ Other ___

☒ Patient may be discharged in 20-30 minutes if stable.

MD signature [signature]
MD name ALLISON BRYANT, M.D.
DEA# BB7855072

AB 01
PPLM 1/04

Planned Parenthood
League of Massachusetts

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DOB: 05/17/61 Age: 42
Chart #:10140698
DOS: 04/09/04

ASOUND EXAMINATION REPORT

Patient's Name: _____ Chart # _____

G_____ P_____ A_____ SAB_____ C-SEC_____ ECTOPIC_____

LMP: Feb 24 GA by LMP: 6w1d

☒ YES ☐ NO Do you want to know if yo

***You will NOT be able to see the scre

Indication:

- ☒ Pre-op AB
- ☐ Dating
- ☐ Medical AB
- ☐ Post-op AB ☐ pain ☐ ble

Other applicable patient history:

GS Diameter: _____ mm

Yolk Sac Seen (circle one) YES NO

CRL: 6 mm

BPD: _____ mm

FL: _____ mm

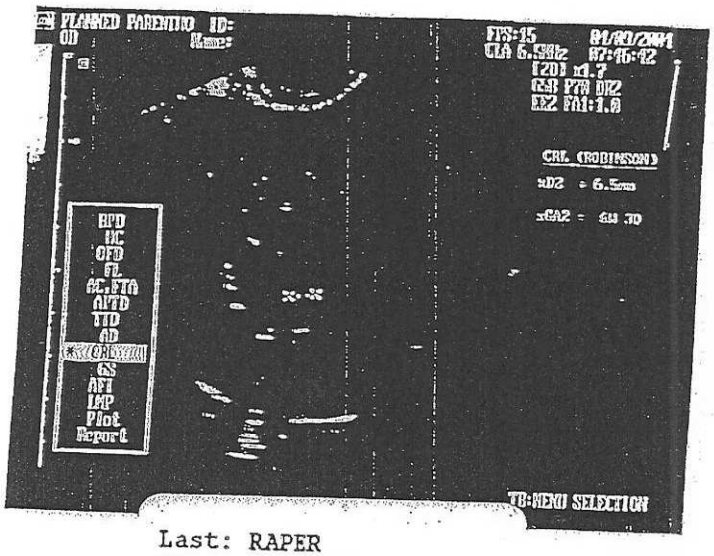
FH Seen (circle one) YES NO

Placental Placement (if indicated): _____

Impression:

GA by U/S: 6w3d

☒ Singleton IUP ☐ Multiple IUP



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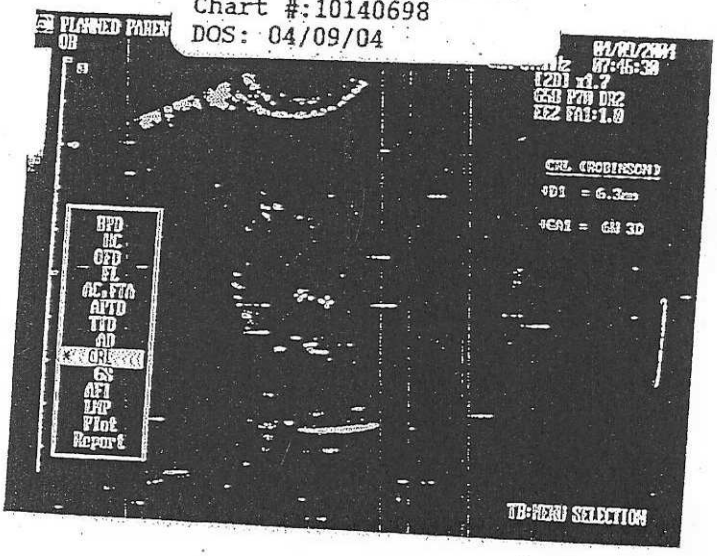

Examiner Signature PAMELA WALLACE, CA

Examiner Name

Physician

☒ Greater Boston Center
1055 Commonwealth Avenue
Boston, MA 02215-1001
(617) 616-1600
(800) 682-9218
Fax (617) 616-1617

☐ Central Massachusetts Center
631 Lincoln Street
Worcester, MA 01605-2010
(508) 854-3300
(800) 539-2378
Fax (508) 854-3310

☐ Western Massachusetts Center
3550 Main Street Suite 201
Springfield, MA 01107
(413) 732-1620
(800) 642-5665
Fax (413) 739-5812

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PLANNED PARENTHOOD® LEAGUE OF MASSACHUSETTS, INC.
Boston Worcester Springfield

Abortion Service Intake

PLEASE PRINT *Please complete this form as accurately as you can.*

Name Jennifer Raper Date of Birth 5/17/61 Age 42

Address 49 Corey ST Apt # 668 City Charlestown State MA Zip 02129

Phone: Day (617) ~~[illegible]~~ 241-0139 Evening ( ) Soc. Sec. # 033-50-3696

Do you have a primary care provider? ☑ YES ☐ NO If yes, specify: Mattapan Health

Staff use only: Mail: PP envelope / Non-PP envelope Phone daytime: PP / MD / KK Phone evening: PP / MD / KK
No home contact, special contact instructions:

MEDICAL HISTORY

1. The first day of my last menstrual period was: 2/24/04

		Dates:
____	Currently pregnant	
# 3	Vaginal deliveries	1991, 1990, 1987
# 1	Caesarean sections	1980
# 3	Abortions	
# 1	Miscarriages	
# ____	Stillbirths	
# ____	Ectopic (tubal) pregnancies	

9 TOTAL NUMBER OF TIMES PREGNANT

2. Are you breastfeeding now? YES ☐ NO ☑

3. During your previous pregnancies, have you ever had any complications?
   ☐ YES ☑ NO
   ☐ hemorrhage after delivery or abortion ☐ retained placenta
   ☐ serious infection ☐ other: ____

4. I am interested in a birth control method today: ☐ YES ☐ NO
   Which ones? ____

5. I am allergic to:
   ☐ iodine or shellfish ☐ local anesthesia ☐ latex
   ☐ medications: ____
   ☑ I have no known drug allergies

6. Have you ever had problems with conscious sedation or anesthesia?
   ☐ YES ☑ NO Explain: ____

7. I have asthma: ☑ NO **(if no, please turn page over)**
   ☐ YES (If yes, please answer the following questions)

   a. Have you been in the hospital for your asthma in the past month?
      ☐ NO ☐ YES

   b. How often do you use your inhaler?
      ☐ 0-2 times per week
      ☐ more than twice per week

   c. What usually triggers an asthmatic attack for you? (for example, stress, medications, dust, etc.) ____

Staff Notes

Allergic response:

Rh Negative Label

Allergy Label

PLEASE TURN OVER.

AB 41
PPLM 11/03

Affix Patient Label Here

MEDICAL HISTORY, cont.

Staff Notes

I have or have had:

YES ☐ NO ☑ chronic anemia
YES ☐ NO ☑ a blood clotting disorder or take blood thinners
YES ☐ NO ☑ cancer; specify: _____
YES ☐ NO ☑ diabetes; Do you take insulin? ☐ YES ☐ NO
YES ☐ NO ☑ epilepsy or seizures
YES ☐ NO ☑ heart disease, heart murmur, or irregular heart beat
YES ☐ NO ☑ stroke
YES ☐ NO ☑ thyroid disease
YES ☐ NO ☑ sexually transmitted diseases (circle):
chlamydia / gonorrhea / herpes / syphilis / genital warts / PID
YES ☐ NO ☑ high blood pressure
YES ☐ NO ☑ HIV / AIDS
YES ☐ NO ☑ Crohn's disease / ulcerative colitis
YES ☐ NO ☑ liver disease / hepatitis B, C / jaundice / mono
YES ☐ NO ☑ abnormal pap smear
YES ☐ NO ☑ treatments / surgery to the cervix
YES ☐ NO ☑ severe headaches / migraines
YES ☐ NO ☑ blood clots in legs or lungs
YES ☐ NO ☑ severe depression or anxiety
YES ☐ NO ☑ under care of therapist or psychiatrist
YES ☐ NO ☑ other medical conditions: _____
YES ☐ NO ☑ kidney disorder
YES ☐ NO ☑ adrenal gland disorder
YES ☐ NO ☑ high cholesterol
YES ☐ NO ☑ umps in breast

- Please list any major surgeries or hospitalizations you have had:
  Cyst in my left breast - removed 2003 OK
- The medications I take are:
  None
- When was your last pap test? 2003 Result Negative

****The Center for Disease Control (CDC) recommends that women under the age of 25 be screened for chlamydia.****

YES ☐ NO ☑ Do you want to be screened for chlamydia at today's visit?
YES ☐ NO ☑ Do you smoke?
If so, how many cigarettes per day? _____
YES ☐ NO ☑ Do you drink alcohol?
If so, how often / how much? _____
YES ☐ NO ☑ Have you used street drugs in the last 24 hours?
If so, what? _____
YES ☐ NO ☑ Have you ever been afraid in any of your relationships?
YES ☐ NO ☑ Have you ever been harmed physically or emotionally in any of your relationships?
YES ☐ NO ☑ Is there anything else we should know about you?

_____

Please sign here: Jennifer Lopez Date: 4/9/04 Staff signature: [illegible]