Consent to Abortion (Termination of Pregnancy)

I, _____, hereby consent and authorize Dr. _____ to perform upon me an abortion. I understand that I am pregnant, and that this procedure will terminate and end my pregnancy. My consent to this abortion is both voluntary and informed.

ABORTION

I have been told what an abortion is, how it will be performed, and what procedures are likely to be used. 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, cramping, pain, fever, bleeding, incomplete abortion (requiring a second procedure), infection, blood clot, embolism, disseminated intra-vascular coagulation, rupture of the uterus, perforation or puncture of the uterus and/or bowel, hemorrhage, shock sterility, cardiac arrest, and even death.

I also acknowledge that I have been informed of the medical alternatives to this treatment, including continuing my pregnancy to term, and have had an opportunity to ask any questions. If I requested, the risks involved with pregnancy and birth were explained to me.

Philadelphia Women's Center is committed to participating in ongoing training and education of students, volunteers, community educators, and others. Therefore, I understand that observers may be present in the facility, and may be involved in my care, unless I specifically request that they not be involved.

TESTING

I further consent to and authorize Philadelphia Women's Center to perform all necessary diagnostic tests, studies, sonograms, and procedures which may be required to monitor my health prior to, during, and after the abortion. I understand that the pre-operative ultrasound testing performed is meant to determine gestational age only, and that I will not be informed of any other information such as fetal sex or potential abnormalities. I may be informed if more than one pregnancy is suspected.

ANESTHESIA

It has also been explained to me that, during the abortion, it may be advisable for me to receive anesthesia to alleviate or control pain. I understand that the "local" anesthesia does not always eliminate pain and that in a small number of patients it may cause severe physical reactions or shock. I have also been advised that IV sedation will render me unconscious and may cause bodily reactions or serious complications requiring additional measures and treatments. I understand that if I receive sedation, I will not be allowed to leave the clinic 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 the IV sedation. I understand that my need for anesthesia may increase if the abortion is more complicated than expected.

I have been informed of the kind of anesthesia likely to be used during the abortion, and of the potential health risks and the possibility of complications from the anesthesia itself. The risks include, but are not limited to, nausea, headache, damage to mouth and teeth, injury to airway and vocal cords, convulsions, phlebitis, respiratory failure, cardiac arrest, prolonged unconsciousness, and even death. I accept the potential risks and specifically consent to and authorize the use of one or more kinds of anesthesia as my Doctor may deem appropriate in the circumstances.

COMPLICATIONS

I also acknowledge that, although my Doctor has made every effort to anticipate problems I may have during the abortion procedure, certain complications cannot be predicted. Among problems which may occur, I acknowledge that:

- In the event I experience an excessive loss of blood or a dangerous change in my condition, I may have to be transferred to another facility where I may require additional treatment, including possibly a blood transfusion.
- In the event of a multiple pregnancy, a second abortion procedure may be required.
- I may be found to have an ectopic pregnancy. This means that my pregnancy may have occurred in the fallopian tubes leading to the uterus. In this case, the abortion may not be successful and I may require immediate hospitalization and surgery, including a D&C or D&E to clear the uterus, removal of a fallopian tube, or even a hysterectomy, which is the surgical removal of the uterus. These procedures may result in permanent sterility or death.
- The abortion procedure may cause cervical incompetence, which may lead to problems during future pregnancies, including miscarriage, stillbirth, premature delivery, low birth weight, and other complications.
- I may experience emotional distress and depression following the performance of the abortion.

There is very little evidence comparing the safety of abortions performed in outpatient facilities with those performed in hospitals; the evidence that does exist indicates abortions are equally safe in both settings.

In signing this consent, I accept the risks of these and any other presently unforeseen, but possible complications, and authorize my Doctor and Philadelphia Women's Center to take necessary and appropriate action to respond to these and any other urgent conditions.

INGESTION

I acknowledge that I was instructed not to eat, drink, smoke or chew anything after midnight the night before my procedure if I am to undergo sedation. I understand the risks involved with IV sedation, and understand that my physician may decide I am not a candidate for IV sedation and/or may be unwilling to perform my procedure if I have ingested anything past midnight the night before the abortion. I also understand that I am responsible for reporting all medications I am currently using.

BLOOD TEST

I understand and agree that you may test my blood to determine if I carry the Rh Negative factor. If my test indicates that I am Rh Negative, I consent to the administration and injection of Gamulin (Rhogam).

TISSUE DISPOSAL

I further consent to the disposal of any tissue that may be removed during the course of the abortion, including but not limited to fetal matter.

FOLLOW-UP CARE

I agree that in the event that I need any follow-up care or treatment following the performance of the abortion, I will contact Philadelphia Women's Center immediately. I further agree that Philadelphia Women's Center will not be responsible for any expenses I may incur for follow-up care or treatment after the abortion. I will bear sole responsibility for all such costs and expenses.

I also confirm that I have been given instructions about medications and follow-up care and have been directed to return to Philadelphia Women's Center for a post-operative check-up, at no additional cost to me, within two (2) to three (3) weeks after the abortion, to determine that I am healing properly. I agree to follow these instructions and return to the Philadelphia Women's Center as directed. If I choose not to return to Philadelphia Women's Center, I agree to have a post-operative check-up at another health facility, at my own expense. I acknowledge that my failure to follow these instructions will relieve Philadelphia Women's Center from any further responsibility to me.

CONSENT TO RECORDS RELEASE

In the event that I am hospitalized, receive care at another facility, or am treated by another healthcare provider immediately following my abortion procedure at Philadelphia Women's Center, I agree to allow Philadelphia Women's Center to obtain records of my care. By signing below, I authorize Philadelphia Women's Center to request these records, and I further authorize the treating hospital, facility, or provider to release such records to Philadelphia Women's Center.

ACT 13: THE PATIENT SAFETY ACT

In compliance with Pennsylvania State law (section 308 of the MCARE Act), Philadelphia Women's Center is required to notify in writing any patient who has been affected by a serious event while obtaining abortion care at Philadelphia Women's Center. In the event that a patient has designated a family member or designee to receive notification of a serious event, the facility may provide written notification to the designated family member or other designee, including the parent or guardian of a minor less than 18 years of age, regardless of whether said parent or guardian consented to the patient's abortion. All such notifications are subject to federal privacy regulations, and notice may not be given if it would endanger the patient, or if giving notice is not in the patient's best interest. A Patient Safety Officer has been appointed to oversee compliance with this regulation.

RELEASE

By signing this form, I acknowledge that I have read it, or had it read to me. I fully understand the contents of the form and have crossed out any sections that I do not consent to. I also understand that without my full consent, my doctor may be unable or unwilling to perform the abortion.

I understand that the physician and the Philadelphia Women's Center staff will rely upon statements that I make, the medical history that I provide, and other information in determining the course of my treatment, and whether or not I am eligible for an abortion procedure. 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 Philadelphia Women's Center staff cannot accept any responsibility for any problems that may result. I have attended and completed an information session at which the risks and complications of, and alternatives to the abortion procedure were explained to me in detail. I have been given the full opportunity to ask questions and my questions have been answered to my satisfaction.

I hereby request and authorize Philadelphia Women's Center to proceed with the abortion procedure. I understand that if I have health insurance, it may not pay for all, or even part, of the cost of this procedure. I agree to pay and be fully responsible for all medical bills and other expenses incurred now, or as a result of this procedure.

Patient Signature Date

Parent/Guardian Signature, if applicable Date

Staff Signature Date

Physician Consultation

I have reviewed this patient's medical history and her reason for having this abortion, and certify that this patient is requesting a voluntary abortion that in my clinical judgment is necessary.

Physician Signature: _____ Date: _____