INFORMED CONSENT FOR PREGNANCY TERMINATION TREATMENT, ANESTHETIC, AND OTHER MEDICAL SERVICES

Name of client

Address

Birth Date

Date 3/29/12

I, _____ request and consent to the performance upon me of a pregnancy termination procedure by vacuum aspiration or standard dilation and evacuation at Dr. Curtis Boyd's office by any of the physicians employed by Curtis Boyd, M.D., P.C.

I further consent to the taking of cultures and performance of reasonably indicated tests and procedures, whether or not relating to presently known conditions, if my medical provider finds these necessary or advisable in the course of evaluation or treatment for pregnancy termination or management of complications.

I have fully and completely disclosed my medical history, including allergies, medical conditions, prior medications, over the counter or other drugs taken, and reactions I have had to anesthetics, medicines, or drugs. I consent to my physicians relying on this disclosure as complete.

I consent that the physician or medical staff may administer such anesthesia and medications as deemed necessary or advisable (including a medication called misoprostol given to prevent bleeding and enhance safety, which has been associated with birth defects), with the exception of *(list any medications which you do not want or are allergic to):*

_____

I understand that local and IV anesthetics do not always eliminate all pain, that in a small number of cases, those anesthetics cause severe reactions or even shock or death, and that no guarantee to the contrary has been made to me. I further understand that any anesthetic will affect my level of consciousness and may, in a small number of cases, cause bodily reactions or complications requiring additional measures and treatment. I understand that the affect on my level of consciousness will impair my ability to make important decisions or operate machinery; I agree to not drive for a period of 30 minutes - 24 hours postoperatively depending on medications given to me. I request and consent to local and/or IV anesthetics.

I understand that the gestation of my pregnancy is determined through multiple methods that may include a urine test, the first date of my last normal menstrual period, and ultrasound measurements taken here in the clinic. Based on these findings, I consent to treatment deemed appropriate by the physician(s) of the Curtis Boyd Clinic, M.D., P.C.

I fully understand that the purpose is to terminate this pregnancy, and I affirm this to be my personal choice in light of the alternative of continuing the pregnancy to term. No one has coerced or compelled me to make this decision.

I understand that tissue and parts will be removed during the procedure, and I consent to their examination and their use in medical research and their disposal by the clinic and/or physician in the manner they deem appropriate.

I understand that the complications associated with early pregnancy termination are generally much less severe and less frequent than with childbirth. Nonetheless, I realize, as is true of childbirth and any kind of surgery, that there are inherent risks of minor and major complications and death which may occur without the fault of the physician.

No guarantee or assurance has been made to me as to the results that may be obtained. The risk of terminating a pregnancy gradually increases throughout the course of the pregnancy. These comparative risks become approximately equal at 16 -18 weeks of pregnancy and increase so that pregnancy termination at 18 weeks and above involves a greater risk than carrying the pregnancy to term.