All Women's Health Center of Gainesville, Inc.

1135 N.W. 23rd Avenue, Suite N. Gainesville, FL 32609 * (352) 378-9191

Thank you for choosing All Women's Health Center of Gainesville, Inc. for your medical needs. We will do our very best to provide you with confidential, courteous and professional care.

Please help us to help others by indicating below how you became aware of our services.

Please check one:

_____**Newspaper (which one?)**

_____Gainesville Sun

_____Alligator

_____Forest High

_____**Prior Patient**

_____**Friend**

_____**Sign**

_____**Physician**

_____**Planned Parenthood**

__✓__**Health Department**

NUMBER CALLED FOR APPOINTMENT
CHECK ONE _____378-9191
_____622-5277
_____1-800-869-0440
_____1-800-347-5277

Phone Book (which one?)

_____Gainesville

_____Palatka

_____Williston

_____Bronson

_____Starke

_____Lake City

_____Hastings

_____Live Oak

_____High Springs

_____Ocala-Marion Countywide

_____Citra

_____Valdosta, GA

_____Citrus County

_____Dunellon

_____Tallahassee

_____Source Book (N. Central FL)

_____Tifton, GA

_____Baxley, GA

_____Madison

_____Thomasville, GA

_____Perry

_____Quincy

_____Other_____

Please indicate the heading you looked under to find us in the phone book:

_____Clinics

_____Clinics-Abortion

_____Abortion Services

Jessica Scofield _____ 9-30-97 _____

Date

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(Contact Boyfriend 344-8179 (E.J)

TE 9-30-97

ME Jessica Scofield DATE OF BIRTH 10-25-83 AGE 14

ME ADDRESS 10333 S. Paloma Tr. CITY Floral City STATE FL ZIP 34436

NE (352) 726-0696 BUSINESS ADDRESS _____ BUS. PHONE _____

ITAL STATUS: S ____ M ____ DIV. ____ WID. ____ SEP. ____

ERRED BY Hlth Dept Citrus Co GYNECOLOGIST _____

LTH INSURANCE: _____ POLICY # _____

MEDICAL HISTORY

day of last normal Menstrual Period August 5th (8 weeks)

you ever had a pelvic examination? Yes ☐ No ☑

you had a recent pregnancy test? Yes ☑ No ☐ Results Positive

ber of Previous Pregnancies 0 Number Delivered 0 Number Abortions 0

Number Caesarean 0

late of your last delivery _____

late of your last abortion _____

lo you know if you are Rh Pos ____ or Neg ____

ou taking any medications now? If so, please list them: —

you ever had a blood transfusion? If so, when and under what circumstances? —

you ever had a Pap test? If so, when and what was the result? —

/ou ever had female trouble? —

you ever used a Birth Control Method? Yes ☐ No ☑ If so, what method? _____

K YES OR NO IF YOU EVER HAD THE FOLLOWING CONDITIONS:

NO		YES	NO	
☑	Allergic reaction to local anesthetics, Novocaine or Lidocaine	☐	☑	Thyroid Problem
☑	Allergy reaction to Tetracycline	☐	☑	Heart Disease or Heart Surgery
☑	Allergy or reaction to Vistaril, Valium, Methergine	☐	☑	High Blood Pressure
☑	Other Allergies	☐	☑	Hepatitis
☑	Anemia	☐	☑	Sickle Cell Anemia
☑	Asthma	☐	☑	Migraine Headaches
☑	Diabetes	☐	☑	Fainting
☑	Epilepsy	☐	☑	Bleeding Disorder
☑	Rheumatic Fever	☐	☑	Pelvic inflammatory disease, or problem with uterus tubes or ovaries
☑	Blood clots (thrombophlebitis)			

OMMENTS CONCERNING YOUR HEALTH? List primary surgery and any other illness or symptoms not mentioned.

Jessie Scofield

Signature of Patient

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Jessica Scofield Date: 9-30-97

ition to the medical history questionnaire you have been asked to complete, we would like you to take ient to answer the questions below, if you are considering any method of birth control. This will enable nake a more complete evaluation of your health and your suitability for a birth control method. During ling please feel free to elaborate on any health concerns you may have and discuss questions with unselor..

BIRTH CONTROL SCREENING

ou ever had:	NO	YES
n legs, lungs, or elsewhere	✓	
e, heart attack, or chest pain	✓	
or suspected cancer of the breast or sex organs	✓	
liver disease		
ır or scanty periods before starting to take the pill	✓	
nodules, fibrocystic disease of the breast or abnormal mogram	✓	
ıs	✓	
ood pressure	✓	
ıolesterol	✓	
ıe headaches	✓	
ır Kidney disease	✓	
y / Seizures	✓	
depression	✓	
tumors of the uterus	✓	
dder disease	✓	
abnormalities	✓	
ell disease or trait	✓	
smoke cigarettes, How many_____For how many years_____		
a history of breast cancer in your family		

pped one week ago

now have:

l bleeding that has not been diagnosed	✓	
or suspected pregnancy		✓

Jessica Scofield
Signature of Patient

Pap Smear Today

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CONSENT FORM FOR TERMINATION OF PREGNANCY, ANESTHESIA AND OTHER MEDICAL SERVICES

Jessica Scofield, hereby request, authorize and consent to the performance
Name of Patient or Legal Representative

ination of pregnancy on Jessica Scofield to be performed under the direction of a
Name of Patient

, Paul L. Sibley, M.D., licensed by the State of Florida.
Name of Doctor

ne nature, purpose and general details of the abortion procedure have been explained to me, and I have
advised of its inherent risks and hazards.
m aware of the alternative methods of treatment. However, because of my personal circumstances, I am
undergo the termination of pregnancy (abortion).
the event that an unforeseen or unexplained situation arises with regard to my condition, I hereby autho
est and consent to the administration and performance of any additional medical or surgical treatmen
necessary and reasonable by the above named doctor or his associate, under the circumstances for the
sts of my health, with the exception of:

NE

(If no exception - state "None")

nsent to the administration of blood and/or blood substitutes and/or such medications, treatments and
as may be deemed advisable, in the judgment of the attending physician, in order to maintain the best
f the patient in regard to her health and life.
nsent to the examination and disposal by the Center of all products of conception which may be removed
nce with the procedures used for the termination of the pregnancy.
n suffering from no mental, emotional or physical disability which would affect my ability to make a knowl-
intelligent and rational decision to terminate my pregnancy.
n not acting under any mental or physical form of coercion in making this decision, and do so voluntarily,
free will and accord. I have not been coerced or otherwise influenced by any employee of this Center
my decision to terminate my pregnancy.
knowledge that no assurance or guarantee has been offered to me as to the results that may be obtained.
reby acknowledge that I have read all of the above and that I fully understand the meaning of the
made.

Witness

Jessica Scofield
Signature of Patient

9-30-97
Date

ıd your doctor are considering terminating your pregnancy. A common method of doing this is ıte or widen the opening of the uterus or "womb" and remove the contents of the womb by s of suction. Complications from abortion are uncommon in the hands of trained medical per- l; however, complications do sometimes occur. Because of this fact your doctor can make no ntee as to the result that might be obtained from this operation. *However, the complication rate s type of abortion is less than the complication rate for continuing the pregnancy.*

any surgical procedure, bleeding and infection are potential complications of abortion proce- These complications could cause prolonged illness, the need for blood transfusions, and per- ıt disability. Perforation or puncture of the wall of the uterus is a rare complication of abortion. omplication could cause pelvic bleeding and infection and even bleeding and infection in the Blood clots in the legs, pelvis, and lungs are other rare complications of abortion. Some of the ications of this operation can require further major surgery; some could potentially result in y or the permanent inability to become pregnant again; and very rarely, some of the complica- :an even be fatal.

r, I understand that the decision to terminate my pregnancy is an emotional issue, as well as a al one. I have been informed and understand that the termination of my pregnancy can result in 'erse psychological reaction at a later date. I do not hold the Center, or any employee thereof, ısible for any psychological reaction resulting from the termination of pregnancy or other treat- ɔffered by the Center, and hereby represent and warrant that they have done nothing to create, ate or otherwise cause such a reaction. I understand there has been a study that has indicated ıving an abortion could increase the risk of breast cancer. The annual risk of breast cancer for a .r old woman might increase from 0.4 to 0.6 per 1,000 women. The alternative to abortion is to your pregnancy to continue; however, as mentioned, this too has the risk of complications. gh the complications listed are rare, it is necessary that you be made aware of them.

TIFY: I have read or have had read to me the contents of this form; I understand the risks ternatives involved and have no further questions regarding the procedure.

9-30-97 SIGNED: Jessie Scofield
(BY PATIENT OR PERSON LEGALLY AUTHORIZED TO CONSENT FOR PATIENT)

:SS: M Smith

rstand that the physician performing the procedure may or may not be an employee or agent of nter. I further understand that the physician is engaged by the Center to perform services by n methods and the performance of professional services are not controlled or subject to control Center.

9-30-97 SIGNED: Jessie Scofield
(BY PATIENT OR PERSON LEGALLY AUTHORIZED TO CONSENT FOR PATIENT)

:SS: M Smith

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Valium, Versed, Stadol, and Sublimaze are effective tranquilizers that have been used to reduce anxiety in patients in many circumstances. Intravenous administration gives an almost immediate calming effect without the pain associated with an intramuscular injection or the prolonged delay when given orally.

We recommend intravenous (I.V.) sedation to our patients for the tranquil effect it provides and to relieve the anxiety that women who undergo an abortion sometimes experience.

If you request I.V. sedation, there are certain conditions which must be met to insure your safety both during and after your abortion:

1) You must have a person available to drive you home from our center, and we urge you not to drive or operate any machinery for at least eight (8) hours after receiving I.V. sedation.

2) As with having an abortion, it is imperative that you have not taken any narcotics, barbiturates, tranquilizers or alcohol for at least twelve (12) hours prior. Also included in this list are illicit drugs such as cocaine, heroin or marijuana.

3) You should not have a known hypersensitivity or allergy to Valium, Versed, Stadol, or Sublimaze, and you should not have the medical condition known as glaucoma.

Although complications and side effects from I.V. sedation are rare, we would like to explain some possible adverse reactions to adequately inform you.

1) Drowsiness and fatigue are the most common side effects.

2) A reddened, tender area where the medication was given may occur. If it does, apply hot compresses and contact our center.

3) Bizarre, serious side effects which could even include cardiac arrest (death) must also be mentioned although these rare complications tend to be limited to the elderly and to very ill patients with lung disease.

ou receive I.V. sedation, it will be administered after the or has examined you and just prior to your abortion. We trust it will make you less apprehensive and that the entire edure will be less traumatic for you. The counselor will uss I.V. sedation with you, and she will answer any questions may have.

nsent to the administration of I.V. sedation and acknowledge I have read all of the above and understand the effects and ible complications associated with I.V. sedation.

ess

Signature of Patient

9-30-97

Date

ll Women's Health Center of Gainesville, Inc.

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INFORMED CONSENT

HBV (HEPATITIS B VIRUS) HIV (HUMAN IMMUNODEFICIENCY VIRUS)

s form, when signed, will indicate authorization and consent to obtaining od from me for the purpose of conducting an HIV and/or HBV test IN THE NT OF BLOOD OR FLUID EXPOSURE TO MEDICAL PERSONNEL INVOLVED IN MY CARE.

the event that such exposure does occur, I understand that I will be lfied and that such exposure will be documented in my medical record.

derstand that these tests are not 100% reliable and may, in some cases, .cate that a person has antibodies to the virus when the person does not .se positive) or fail to detect that a person has antibodies (false tive). I have also been informed that a positive blood test result does mean that I have Hepatitis B or AIDS, and in order to be properly nosed other means must be used in conjunction with the blood test. I rstand that a second or confirmatory test may be necessary before any results are released and that I will be provided with an opportunity for -to-face counseling.

derstand that, if there is a positive test result, those health care titioners who are directly responsible for my care and treatment will be rmed of this result so that proper precautions may be observed.

rther understand that any information regarding my test results held by health care facility, its employees or agents, any physicians, any ratory or blood bank, any insurance company, health benefit plan, care/Medicaid, or other third party payor, the state or local department ealth, or any other agency shall be strictly confidential and shall not isclosed to any other agency or institution or made public, except where ersonal identifiers are removed from such information.

y signature below, I acknowledge that I have read this consent form and rstand the provisions for release of information set forth in this ent.

READ BEFORE SIGNING

ent: Jessica Scofield DATE 9-30-97

ess: Carol Ann Eldyer

All Women's Health Center of Gainesville, Inc

1135 N.W. 23rd Ave., Suite N. • Gainesville, Florida 32601 • (352) 378-9191

DATE 9-30-97

I Jessica Scofield have been scheduled for an examination on 10/21 1997 following my abortion of 9-30-97.

I understand the importance of this follow up evaluation and agree to return on the scheduled day.

I understand that it is my responsibility to see that I obtain this check up and if I cannot keep the original appointment to call the Center and reschedule.

I further understand that my failure to return for this examination and evaluation relieves the Center, it's physicians, employees and agents from responsibility for possible problems or consequences that could arise as a result of my failure to return to the Center.

Signed Jessica Scofield

Witness

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COUNSELING SHEET

ssica Seafield. LMP 8-5-97 DATE 9-30-97

IRTH 6-25-83 DOCTOR Paul L. Sibley, M.D

ING NOTES:

OR TERMINATION:

M Smith
COUNSELOR

ION

DECISION

& ALTERNATIVES UNDERSTOOD (INCLUDING RELATIVE COSTS, GENERAL ANESTHESIA AND ADOPTION)

JRE EXPLAINED & UNDERSTOOD

OMPLICATIONS UNDERSTOOD

NTIALITY POLICY EXPLAINED

ERATIVE INSTRUCTIONS EXPLAINED AND UNDERSTOOD

POST OPERATIVE INSTRUCTIONS GIVEN

NCY CONTACT DOES OR DOES NOT KNOW ABOUT AB

WHO E.J. - driver PHONE NUMBER

APPOINTMENT: DATE 10/21 10/22 HERE ✓ PMD OTHER

XCUSE: GIVEN ✓ NOT NEEDED

ITROL CHOICE:

LOESTRIN 1.5/30

LOESTRIN 1/20

OTHER OC BRAND Estrostep 28

SAMPLE 1 REFILLS

PROVERA

NORPLANT DIAPHRAGM

M & CONDOM

L, VASECTOMY

ER

IATURE

RX HERE X OUT

TETRACYCLINE 500 mg. BID x 5 days

METHERGINE 0.2 mg. Qid x 3 days

ANALGESIC Anaprox DS x 12 TABS.

OTHER

E SUMMARY discharged to E.J.
Instructions given
needs 6 week p/op
procedures

C. Lowen
COUNSELOR OR NURSE

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MEDICAL PROCEDURE

Date 9-30-97 Patient's Name Jessica Scofield.

SICAL EXAM	VITAL SIGNS	LABORATORY		RECOVERY		RHOGAM
HT. 5'6"	EJ	EJ		CL	CL	
WT. 111						
ENERAL	BP 108/62	HCT 38	TIME	11:30 AM	11:40	☐ Accepted
EART	TEMP 98.7	Rh +	BP	114/76	114/70	☐ Refused
INGS	PULSE 68	URINE N/N	PULSE	72	72	☒ Not Needed
BDOMEN	RESP 22	PREG. TEST +	BLEEDING	recent	—	
ELVIC Uterus Adnexa						

CONDITION ON DISCHARGE Stable

patient was evaluated in the Center on 9-30-97 and found to be 6/7 weeks pregnant. She ested an abortion. She was seen by a trained counselor where the procedure and other options were ex ed, birth control information was given and all questions were answered. During her counseling, a decisior irth control methodology was made. The operative technique was as follows: The patient was place in the al lithotomy position and prepped and draped in the usual manner for suction D & C. A speculum was placed e vagina. A paracervical block was then performed using xylocaine 1%. A curved single toothed tenaculun hen placed in the anterior lip of the cervix and the cervical os was dilated up through # 29 Prat or. A _____ ml. disposable plastic curette was then introduced through the internal os and the content evacuated with suction. Following this the completion of the procedure was confirmed with a sharp curette ollowing medications were given:

morphine 5mg IV @ 10:32, Eeg Maleate 0.2mg IV @ 11:2

vas given prescriptions for methergine gr. 1/320 per os q 6 doses and tetracycline 500 mg. q.i.d. for 5 days patient was given a post-operative instruction sheet. She will return to the Center in 3 weeks for a post itive visit. 10/21 10/22

of Birth Control recommended:

Nitrous oxide administered 6/7 3

Duration _____

Jrostep 28

-Operative Check-Up

- omen _____
- ia _____
- ix _____
- is _____
- xa _____
- r _____

Physician

certified letter sent 11-20-97

"I HAVE DISCUSSED POSSIBLE COMPLICATIONS WITH THE PATIENT WHO VERBALIZES THAT SHE UNDERSTANDS.

PATIENT FAILED TO SHOW FOR RETURN VISIT ON 10-21 or 10-22

Physician

, Paul L. Sibley, M.D

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CLINIC EXAMINATION OF PRODUCTS OF CONCEPTION

nt's Name: Jessica Scofield Date: 9-30-97

perative estimate of Gestational Age

6 wks

ination of Products of Conception:

Tissue Weight: 4 g

Products of Conception grossly identified: (Check all applicable)

Fetal parts ?

Membranes ?

Placenta or villi ?

None

Specimen to Lab: Yes x No

Further Action Taken (if any):

ed: Date: 9-30-97

PROFESSIONAL ARTS LABORATORY

P.O. BOX 507
404 SOUTH LOGAN STREET
WEST FRANKFORT, ILLINOIS 62896
PHONE 1-800-333-1721
FAX 618-937-1525

MILES J. JONES, M.D. (FCAP)
PATHOLOGIST

GAYLA D. ROSE
DIRECTOR

SURGICAL PATHOLOGY REPORT

PATIENT NAME: SCOFIELD, JESSICA
SPECIMEN NUMBER: C97-115451
REQUISITION NUMBER: 9462
BLOCK NUMBER: 4745
DATE COLLECTED: 9/30/97
DATE RECEIVED: 10/4/97
PATIENT AGE: 14
LOCATION: AWG
PATIENT SEX: FE
PHYSICIAN: SIBLEY
REPORT DATE: 10/6/97

Pre-Op Diagnosis: Intrauterine Pregnancy
Specimen Location: Uterus
Received is a specimen identified as Products of Conception.

WEIGHT: 20 gms
PERCENT BLOOD CLOT: 1%
PERCENT T ISSUE: 99%
Note: Abnormal Fetal Tissue, Hydropic Villi, Intact Gestational Sac, absence of Fetal or Placental Tissue, or the presence of Necrotic or Degenerative Tissue requires a microscopic diagnosis if not previously requested

FETAL TISSUE		PLACENTAL TISSUE	
a. Limbs	: NO	a. Normal Placental Tissue	: YES
b. Trunk	: NO	b. Hydropic Villi	: NO
c. Umbilical Cord	: NO	c. Intact Gestational Sac	: NO
d. Unclassified Fetal Tissue	: NO	d. Abnormal, Necrotic, or Degenerating Tissue	: NO
e. Abnormal Fetal Tissue	: NO	e. Decidual Tissue	: YES

MICROSCOPIC: REPRESENTATIVE SECTION SUBMITTED.
SECTIONS CONTAIN PORTIONS OF FETAL MEMBRANES WHICH SHOW NO EVIDENCE OF INFLAMMATORY REATION IN ADDITION, THESE CHORIONIC VILLI DISPLAY LINING BY SYNCYTIAL TROPHOBLASTS. OCCASIONAL SYNCYTIAL KNOTS ARE FORMED.

DIAGNOSIS:
PLACENTAL AND DECIDUAL TISSUE (PRODUCTS OF CONCEPTION).
CHORIONIC VILLI PRESENT.

MILES J. JONES, M.D. (FCAP)
PATHOLOGIST

ps 10/14 (2)

Vomens Health Center
ille

Medication Information & Request Form

RTANT INFORMATION ABOUT YOUR MEDICATIONS
Please read carefully and sign

you complete your visit today, you will be given prescriptions for three types lication:

TRACYCLINE.....*an antibiotic which will prevent infection*
THERGINE.....*a drug to help your uterus contract to normal size*
APROX (*optional*)....*used to relieve painful cramping*

ur convenience, you may purchase these medications here. If you wish to se check below and provide payment as indicated.
have an insurance card or wish to purchase these medications at your local please indicate by checking the second box below.

ES, *I wish to purchase these medications from the clinic today:*

TETRACYCLINE	*(check here)*	☐	$ 5.00
METHERGINE	*(check here)*	☐	$ 14.00
ANAPROX	*(check here)*	☐	$ 12.00
	TOTAL		$ 19.00

paying by: (*check one*) cash ☑ credit card ☐

O, *I do not wish to purchase the prescribed medications now. furnish me with a written prescription that I can use to obtain edications at any pharmacy.*

❀❀❀

nd that if I fail to begin these medications immediately, as directed and until finished, I risk serious complications ld jeopardize my future health and fertility.

Please sign here ☞ Jessie Scafield
(your signature)

DATE 9/30/97 STAFF INITIALS CP

All Women's Health Center
Gainesville

E: 10-8-97 19____

RELEASE OF RECORDS AUTHORIZATION

ereby authorize and request you to release my history of medical
ords in your possession to/the;

Father Steven Scofield

ied: Jessie Scofield
ness: Kathleen A. Olson
: 10-8-97