FEMI-CARE SURGERY CENTER, LLC

CONSENT TO VOLUNTARY ABORTION, PROVISIONS OF CONTRACEPTION, LABORATORY TEST, AND DISCLOSURE OF PAST MEDICAL HISTORY

I, ______________________________ am __________, years old, and request and consent to the performance upon me of a pregnancy termination by the procedure__________________________ performed by Dr. Sheo P. Sharma.

This form has been designed with the understanding that you have, at least tentatively, decided to have an abortion. The information contained in this form is not intended to frighten or upset you. It is also not meant to influence your decision in any way.

What this form is meant to do is give you information. We believe you need complete and up-to-date information about the safety of abortion, an understanding of the risks involved, and an explanation of the test and medications that are provided with the abortion procedure. We urge you to read this form carefully. If you have any questions, please ask.

MEDICAL HISTORY: I have fully disclosed my medical history and have listed the following allergies or reactions to medications: __________________________. I (do)/ (do not) have a history of rheumatic fever. The first day of my last menstrual period was ___________________, and I believe that I am about____________________ weeks pregnant. A pelvic exam and vaginal ultrasound are performed for this purpose.

LABORATORY TESTS: I consent to taking of blood samples, a urinalysis, and a urine pregnancy test. I understand these tests are performed for this purpose.

USE OF ANESETHETICS:

Please circle which method of anesthesia you prefer:

A. LOCAL: I consent to the administration of local anesthetics. I understand that these do not always have to eliminate all pain. In a very small number of cases. Local anesthetics cause severe reactions including rare instances of convulsions, cardiac arrest, or prolonged unconsciousness.
B. TWILIGHT: I consent to the administration of a mild sedative, which will induce a calming effect to help me relax during the procedure. Side effects most commonly reported include drowsiness, fatigue, and poor muscular coordination after receiving the sedative. I am aware that I will not be able to engage in hazardous activities that require complete mental alertness, such as operating machinery or driving a car.
C. GENERAL: I have been informed that disorientation, allergic reactions to the anesthetic, cardiac arrest, laryngospasm, aspiration, pneumonia, coma, and death are possible complications with general anesthesia. I acknowledge that no guarantee has been given to me by the staff. I understand that I am responsible for all physician and hospital charges should hospitalization be required. I consent to the administration of general anesthesia.

I certify that I have not had anything by mouth since midnight yesterday and have transportation with me.

____________________ (Patient Signature)

____

CRNA Signature/Date

PURPOSE OF ABORTION: I fully understand that the purpose of this abortion is to end my pregnancy. I know that I can continue to its full term, but it's MY personal choice to end the pregnancy at this time.

RISKS AND COMPLICATIONS: In any surgical procedure, there are risks of minor and major complications which may not be the fault of the physician. These risks are relatively low: 95% of these procedures are without complications. The following are examples of the complications that can occur:

A. Infection of the uterus, which may require antibiotic therapy and rarely can lead to the loss of childbearing capacity.
B. Failure to remove all of the tissue which may require resuctioning.
C. Hemorrhage (heavy bleeding) which will require re-evaluation of the patient to determine causes of the excessive bleeding.
D. Perforation or injury of the uterine walls, which may occur in one in a thousand procedures. This requires hospitalization, and may require surgery. Occasionally removal of the uterus resulting in the loss of childbearing capacity may occur.

E. With uterine perforation, bowel or bladder injury can occur, requiring surgical repair and rarely removal of a portion of the injured bowel.

F. Laceration (tearing of) the cervix, which may require suturing.

G. Continuing pregnancy, this may occur as often as one in 500 cases, and may be due to multiple pregnancies, double uteri, or pregnancy in the fallopian tubes (ectopic pregnancy). A failed abortion requires resuctioning. A tubal pregnancy requires hospitalization and surgery.

H. Post abortion syndrome, retention of blood clots in the uterus, requiring resuctioning. This occurs in less than one percent of patients.

I. In very rare cases, death may occur due to very heavy bleeding and septic shock from infection.

According to the center for Disease Control in Atlanta and the American Medical Association, a first trimester abortion is five to ten times safer than a full term delivery.

<u>DISPOSAL OF FETAL TSSUE</u>: I understand that the tissue and parts will be removed during the abortion, and I consent to having them disposed of by Femi-Care Surgery Center in a matter they believe appropriate.

<u>IN THE EVENT OF AN EMERGENCY</u>: I have been informed that Femi-Care Surgery Center, LLC has a physician who has hospital privileges at Sinai Hospital or a nearby hospital and this physician will attend to any emergencies that may have to be treated in the hospital, and I consent to having said physician treat me in case of any complications. I understand that patient confidentiality cannot be preserved if transfer to a hospital is necessary. Also, I understand that I am responsible for the cost of any treatment related to the complication of this abortion. Should an emergency occur, please contact:

____

Name Address Phone Relationship

I understand the above risks and accept them. No guarantees have been made known to me. I realize that the long-range physical and mental effect of a therapeutic abortion is unknown and therefore, no future guarantees can be given to me.

I will read the follow-care instruction sheet and will call the center immediately if I have any adverse reactions.

I will check my temperature regularly and will call the center immediately if any temperature is over 100.4 degrees.

I realize the importance of having a follow-up examination with 2-4 weeks of my treatment here.

I, ______________________________, am __________ years old and request and consent to the performance of vacuum curettage for the termination of my pregnancy. No one has coached or compelled me to have this done. I have read and fully understand the above.

O (check off) I have received the written information on the following: Centers Policy on Advance Directive, My physician disclosure ownership, Patients' Bill of Rights and how my health information can be utilized.

______________________________ ______________________________

Witness Signature Patient Signature Date

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Physician Signature Date