



1011 Monticello Court
Montgomery, AL 36117

Consent To Outpatient Surgery

Vacuum aspiration (VA) Dilatation & Evacuation (D&E)

VOLUNTARY TERMINATION OF PREGNANCY

Date _____

This form is your written request for an abortion and your written consent to having the surgery. It provides information about the surgery and its possible risks and complications. Do not sign this form without reading it completely, listening to the explanations given by your counselor, asking questions and fully understanding its contents. You may ask for a copy of this form.

I, _____, Age _____, hereby give my consent to and request and authorize Dr. and assistants of his/her choosing to perform an ABORTION on me. I fully understand that this abortion will end my pregnancy and this is my personal choice. No one has forced or compelled me to end my pregnancy. The first day of my last normal menstrual period was _____.

Please read each section, listen to the counselor's explanation and ask any questions. Write in your initials on the line next to each section indicating that you understand and accept the information given in the section.

_____ **DIAGNOSIS:** Tests and/or examinations have indicated that I am pregnant. I understand that it is possible for tests and/or examinations to be inaccurate. I am aware that the determination of the length of pregnancy may be in error by approximately 2 weeks. I also understand that there is a very small possibility that this procedure will be performed in the absence of pregnancy.

_____ **PURPOSE OF ABORTION:** I understand the purpose of an abortion is to end my pregnancy.

_____ **PROCEDURE:** I understand that my first trimester abortion consists of stretching open the mouth of the uterus (cervix) and removing the contents of my uterus-with surgical instruments and gentle suction.

_____ **ALTERNATIVES TO ABORTION:** I understand that the alternatives to abortion are to carry the pregnancy to term and become a parent or utilize adoption services. I have considered these alternatives and the staff here have offered to make referrals to appropriate agencies for birth and/or adoption. I reject these alternatives and request that the abortion procedure be performed.

_____ **MATERIAL RISKS OF SURGERY: As a result of surgical procedures, there may be material risks of: INFECTION, ALLERGIC REACTION, DISFIGURING SCARS, SEVERE LOSS OF BLOOD, LOSS OF OR LOSS OF FUNCTION OF A LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLÉGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH.**

In addition to these material risks, there may be other POSSIBLE RISKS involved in this procedure including but not limited to:

- _____ • Perforation (a puncture or tear) of the wall of the uterus and/or other organs, including fallopian tubes, ureter, bladder and bowel which may require immediate surgery;
- _____ • Cervical tear, which may require stitches;
- _____ • Formation of blood clots in the uterus which may require repeat suctioning;
- _____ • Hemorrhage (excessive blood loss) may require medication and/or repeat of the abortion procedure. Rarely, blood transfusions are necessary (this carries the risk of exposure to hepatitis and other infectious diseases);
- _____ • DIC (disseminated intravascular coagulation), the inability to clot blood which can be fatal;
- _____ • Fistula formation (an opening between bowel, bladder, ureter, vagina and/or skin) caused by an injury to the bowel, bladder or ureter;
- _____ • Emboli (clots of blood or other material, including amniotic fluid emboli) that might travel to other parts of the body, this condition may be fatal;
- _____ • Incomplete abortion occurs when some tissue from the pregnancy remains in the uterus; the procedure may have to be repeated;
- _____ • Missed abortion occurs when the procedure does not end the pregnancy, the abortion will be repeated;
- _____ • Cervical incompetency can cause difficulty in maintaining a pregnancy in the future (possible miscarriage or still birth) or low birth weight, premature delivery or other complications in pregnancy;
- _____ • Emotional distress such as depression or other psychological consequences may occur. I understand that I may call Beacon for additional follow-up counseling and referrals for longer term counseling;

Possible risks of this procedure continued:

- _____ • Infection: In order to help avoid this complication I agree to take the precautions explained to me and listed in the post-operative instructions;
- _____ • **POSSIBLE NEED FOR IMMEDIATE SURGERY OR OTHER ADDITIONAL SURGERY WHICH MIGHT INCLUDE A HYSTERECTOMY (REMOVAL OF THE UTERUS, FALLOPIAN TUBES AND/OR OVARIES), laparoscopy (examination of internal organs) and laparotomy (repair of perforation).** I give my consent for these procedures and understand that they also have material risks and the possibility of other complications.

_____ **ANESTHESIA:** I consent to the administration of anesthesia and authorize the use of such anesthesia as the doctor or his/her assistants deem advisable with the exception of _____. I request _____ anesthesia. I understand the risks of **LOCAL** anesthesia range from minor to severe including convulsions, cardiac arrest and death. I understand the risks of **I.V. Sedation** anesthesia range from minor (nausea, phlebitis) to severe (cardiac arrest, respiratory failure, death). I understand that I should not eat or drink anything but water 6 hours before my surgery time. I have had the following to eat and drink since 6 hours prior to my appointment time of _____ am/pm:

_____ **I ACCEPT ALL THESE RISKS AND TAKE RESPONSIBILITY FOR THEIR CONSEQUENCES.**

_____ **ECTOPIC PREGNANCY:** is a pregnancy located outside the uterus for example, in the fallopian tube) that may rupture or burst. An abortion procedure cannot terminate an ectopic pregnancy. I understand that this is not a complication of the abortion itself, but rather a pre-existing medical condition that is serious and potentially life threatening. Immediate medical attention is required with possible hospitalization and surgery.

_____ **NO GUARANTEES OF ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure. I understand that the practice of medicine is not an exact science. I understand that the physician, medical personnel and other assistants will rely on statements I have made, the medical history I have given and other information in determining whether to perform the procedure and/or my course of treatment. I warrant that I have provided full, complete and truthful information. I have also provided accurate phone numbers and addresses for an emergency contact and myself.

_____ **ADDITIONAL PROCEDURES:** If during the course of the abortion procedure, any unforeseen conditions or complications arise, and the doctor in his/her professional medical judgment decides that different or additional procedures are necessary including but not limited to anesthesia, blood transfusion, the association of another doctor, or transportation to and admission to a hospital. I give my consent to any services as may be necessary. I accept all financial responsibility for payment for any additional services set forth above. I give my permission for my parents (or legal guardian where applicable) or other person (who is noted on the following page) to be notified by the doctor or a Beacon staff member.

_____ **LABORATORY:** I consent to diagnostic studies, tests, ultrasounds (sonograms) and any other treatment or courses of treatment relating to the diagnosis of my condition or the procedures described in this form. I understand that the purpose of my ultrasound examination at Beacon is to determine gestational size only and NOT to rule out or determine fetal abnormalities or deformities or other conditions. I also consent to the disposal of any tissue or other parts of the contents of my uterus (womb) which may be removed during the abortion. I understand that all fetal tissue will be disposed of in a manner consistent with state regulations and community practices for the disposal of surgical pathological specimens. I also consent to the administration of RhoGam (or equivalent) should my blood be Rh negative. I also consent to being contacted by the doctor or clinic staff if necessary regarding lab findings.

_____ **EMERGENCY:** If I develop a fever, heavy bleeding, severe cramping or pain or any other symptom, I agree to notify BEACON at once. I have been given an emergency telephone number that I can call 24 hours a day for assistance. My failure to give notice within 24 hours of the onset of any symptom of a possible complication releases the doctor or clinic from any responsibility to me.

_____ **FOLLOW-UP:** I have been advised to return to Beacon for a follow-up examination within 3-4 weeks of my abortion. I understand that this exam is needed to be sure that no complications or other problems have appeared, that I am not still pregnant, and that the healing process is going on properly. I agree to follow the aftercare instructions provided to me and to take my medications as directed. My failure to obtain follow-up care relieves the doctor and clinic of any responsibility to me.

_____ **By signing this 4-page form,** I acknowledge that I have read or had this form explained to me, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled before I signed this form.

_____ **I voluntarily consent** to allow Dr. (an independent contractor to Beacon Womens Center , Inc.) or any physician designated or selected by him/her and all medical personnel under the direct supervision and control of such physician and all other personnel who may otherwise be involved in providing such procedures to perform my abortion and any other procedures described or otherwise referred to in this form.

Patient Name _____		Notify in Case of Emergency:
Signature _____	Date _____	Name _____
Address _____		Address _____
Daytime Phone _____		Daytime Phone _____
Counselor _____	Date _____	
Translator Name & Signature _____		Date _____

Parent /Guardian/Adult Consent for Minor Patients:

I, _____ am the _____ to the patient whose signature appears above. I have read and had explained to me the matters set forth in the above and hereby request and give my consent. I agree to pay for medical expenses incurred in this or as a result of this procedure.

Adult Signature _____	Date _____
Address _____	Phone _____
Witness _____	Date _____

