

Dear patient,

As a convenience we have provided forms in advance of your appointment for your review. Please note that the ***signing of these forms must be done while you are at the clinic***. If you have any questions one of our staff will be happy to assist you.

## INFORMED CONSENT TO TREATMENT, ANESTHETIC, AND OTHER MEDICAL SERVICES

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I, \_\_\_\_\_ AM \_\_\_\_\_ YEARS OLD, AND I WAS BORN ON \_\_\_\_/\_\_\_\_/\_\_\_\_. I AGREE TO HAVE AN ABORTION AT CONCERNED WOMEN'S CENTER BY THE METHOD OF D & C VACUUM ASPIRATION BY A DESIGNATED PHYSICIAN THAT IS AN INDEPENDENT CONTRACTOR OF CONCERNED WOMEN'S CENTER, INC.

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*PLEASE INITIAL ALL LINES AS YOU READ:*

\_\_\_\_ 1. I HAVE REPORTED MY COMPLETE PRESENT & PAST MEDICAL HISTORY. I HAVE INCLUDED ALLERGIES, BLOOD CONDITIONS, PRIOR MEDICATIONS OR DRUGS TAKEN, & REACTIONS TO ANESTHETICS, MEDICINES, & DRUGS.

\_\_\_\_ 2. The first day of my last menstrual period was \_\_\_\_\_. This period was:      Normal      Heavy      Light

\_\_\_\_ 3. I consent to the physician or his medical attendants giving me anesthesia or pain killers as necessary or advisable. I understand that local anesthetics do not always eliminate all pain, and that in a small number of cases local anesthetics cause extremely severe reactions, including rare instances of shock, cardiac arrest, or prolonged unconsciousness and that no guarantees to the contrary have been made to me.

\_\_\_\_ 4. I fully understand that the purpose of this procedure 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. I have not been forced or compelled to make this decision.

\_\_\_\_ 5. I further agree to the taking of blood samples, cultures, and other tests and procedures which might reasonably be indicated. I also agree that these tests and procedures may or may not relate to my presently known medical condition. I understand that medical attendants may find procedures necessary or advisable in the course of my evaluation or treatment and succeeding any complications or treatments.

\_\_\_\_ 6. I understand the tissue and products of conception will be removed during the abortion procedure and I consent to having them disposed of by the clinic or physician in a manner they believe appropriate.

\_\_\_\_ 7. I understand that the complications associated with abortion are generally much less frequent than with childbirth. I understand that in childbirth some 15 or 20 out of 100,000 women do not survive and that abortion is 5 to 10 times safer. None-the-less, I understand there are risks of minor and major complications which may occur in this procedure, as in all surgical procedures. I realize the possibility of a perforation or tear in the uterus or a laceration of the cervix (2 to 4 in 1,000 cases) or of continued ectopic, twins, missed abortion in about 1 out of every 2,000 cases. I understand the possibility that not all the tissue will be removed, that severe bleeding may occur in 1 to 2 cases per 100 from various cases such as missed tissue, inability of uterus to contract to normal size, or a tear. I recognize that some possibility of sterility may occur in 1 per 1,000 cases, some of which might arise from a necessary hysterectomy.

\_\_\_\_ 8. I understand that if a major complication arises, I may have to be hospitalized with the total costs as my responsibility. I understand the possibility of the above mentioned complications are equal or greater risk of continued pregnancy, and it is my decision to terminate the pregnancy.

\_\_\_\_ 9. I understand also that I may react adversely to medicines or the anesthetics; I may have pain, cramps, or even convulsions; and that I may also have mild or severe reactions to any contraceptives which I may use later. I further realize that such complications may be caused by own existing medical condition or conduct, or treatment by a follow-up physician who is unfamiliar with first trimester abortion practice and its complications.

\_\_\_\_ 10. I understand that the medical practice of my physician is to be judged according to those standards reasonably acceptable to other physicians practicing in similar facilities in the United States.

\_\_\_\_ 11. The possibility of endometritis and pelvic infection may occur after this procedure requiring antibiotics, hospitalization, and/or surgery.

\_\_\_\_ 12. When scheduling my appointment, I received a written statement identifying the Texas Department of Health as the responsible agency for abortion facility complaint investigations. **I received this in written form by AAA Concerned Women's Center website, or by email, or by fax. This written statement provided me with a toll free number that discloses information about abortion facilities.**

\_\_\_\_ 13. I have received after-care instructions regarding an abortion and information regarding possible complications.

\_\_\_\_ 14. I understand that any questions I may have will be answered by a physician, nurse, and/or counselor and I will ask any questions I have before leaving. If I have questions or complications after leaving, I agree to call the clinic at telephone number 713-988-2200 immediately.

**I certify that I will have a pelvic examination 21 to 28 days following the termination of pregnancy. I choose to:**

\_\_\_\_ Return to AAA Concerned Women's Center for this exam.

\_\_\_\_ I will see my own physician.

\_\_\_\_ I give AAA Concerned Women's Center permission to send a medical report to my physician: Name: \_\_\_\_\_.

**I have read and fully understand the above paragraphs. A nurse and/or counselor have discussed with me the abortion procedure and the informed consent for the abortion. I fully understand the information that has been presented, and I consent to go forth with the abortion procedure to end my pregnancy.**

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **am** **pm**

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **am** **pm**