

*Choice
Medical Group*

CONSENT FOR SURGICAL ABORTION

The purpose of this form is to inform you about the surgical abortion procedure that you are considering. You should read this form carefully, and ask any questions that you may have, before you decide whether or not to provide your consent. Your signature below indicates that you have read, understand, and agree with the information in this form. Choice Medical Group shall be referred to hereafter as “CMG”.

- I, _____, have been informed, and understand to my complete satisfaction, the options available regarding my current pregnancy. My options are: (1.) continuation of the pregnancy, (2.) adoption, and (3.) abortion, and I choose to have an abortion to end this pregnancy.
- I acknowledge that I am acting on my own behalf, and that my decision to have an abortion is voluntary.
- I have received information about the treatments and procedures that may be provided. This information included the risks, benefits, possible problems and complications, and alternatives available to me. I have had the opportunity to ask questions about this information, and may do so at any point if I decide that I need further clarification.
- I have viewed the CMG video presentation, and read this form completely. Therefore, I understand all of the risks and complications associated with a surgical abortion procedure. I have had the opportunity to have all of my questions answered to my satisfaction.
- I also understand that if I am early in my pregnancy, I can choose a medical abortion as an alternative to a surgical uterine aspiration. I choose a surgical method for my abortion.
- I have been provided with a full explanation of the surgical procedure that will be used for my abortion, and what to expect after the abortion. I have no questions at this time.
- I understand that a surgical abortion is a safe procedure. However, I am aware that no guarantees have been made to me, and that complications can occur with any surgical procedure. I have received information about the risks involved, and I feel that the benefits of having the abortion outweigh these risks.
- I am aware that, although uncommon, certain complications may occur with abortion procedures performed by qualified and competent medical doctors. The risks that exist include, but are not limited to, the following:
 - a. heavy bleeding, which may require uterine aspiration;
 - b. an incomplete abortion or missed abortion, which may require re-aspiration;
 - c. infection of the uterus, fallopian tubes, or ovaries;
 - d. perforation of the uterus, with damage to the uterus, fallopian tubes, ovaries, bowel, bladder, blood vessels, or nerves, which may require a surgical procedure and abdominal incision to repair;
 - e. hysterectomy (removal of the uterus);
 - f. sterility, or inability to retain future pregnancies;
 - g. cervical stenosis, requiring re-dilation;
 - h. failure of menstrual periods to return;
 - i. formation of scar tissue in the uterus;
 - j. cervical incompetence;
 - k. emotional upset;
 - l. failure of the blood to clot;
 - m. allergic reaction to medications or other products;
 - n. death.
- I authorize _____, M.D., and his/her associates or assistants to perform my abortion, as well as any other necessary services, including but not limited to, the administration of blood or blood products, and performance of services of pathology. In the event of an emergency, I authorize the doctor to perform any procedure deemed necessary for my well-being.
- I have been informed that if I have any problems or need medical advice regarding my abortion, I can seek help at any of the CMG sites during normal business hours, and that CMG is also available 24 hours a day by telephone.

(continued on back)

(continued from other side)

- I understand that if I have any questions or complications, it is my responsibility to contact CMG. If I should be unable to reach CMG through their 24-hour answering service, it is my responsibility to seek whatever emergency care is available. Financial responsibility for care not rendered by CMG is mine; however, any emergency care provided by CMG is without additional cost to me.
- I authorize the disposal of any tissue removed, in accordance with applicable state law.
- I consent to the exchange of medical records between Choice Medical Group and any other provider, physician, hospital, or clinic pertaining to my medical treatment.
- I am fully aware of, and completely understand, all information presented on this consent form. I voluntarily consent to the performance of a surgical abortion procedure. I hereby release CMG, the attending clinicians, and their staff from any liability or responsibility for any condition that results from performing this procedure.

The items in this box do not apply to all surgical abortion procedures performed at CMG. (Please ask a staff member if you are unsure about whether or not the following three items are applicable.)

- I have been informed, and understand to my complete satisfaction, that my abortion procedure at CMG will require the use of laminaria (cervical dilators), misoprostol, or both, for preparation of my cervix.
- I understand that cervical preparation is the start of my abortion procedure. I realize that I must be completely certain about my decision to have an abortion before I begin the cervical preparation phase of the procedure. I am aware that not proceeding with the abortion after cervical preparation is against CMG medical advice, and may cause complications which include, but are not limited to, infection, miscarriage, and excessive bleeding.
- I understand that the risks of laminaria insertion include, but are not limited to:
 - a. perforation of the cervix or uterus;
 - b. puncturing of the amniotic sac (“bag of waters”);
 - c. spontaneous abortion;
 - d. infection;
 - e. allergic reaction.

I consent to a surgical abortion procedure at Choice Medical Group on this date. I have received written instructions for my aftercare following the abortion procedure, and understand these instructions.

Patient’s printed name: _____

Patient signature: _____ **Date:** ____/____/____

CMG staff member witness signature: _____ **Date:** ____/____/____

Clinician signature (if applicable): _____ **Date:** ____/____/____

This patient, named above, has received an explanation of the nature, purpose, benefits, risks, and alternatives to the proposed procedure. I have offered to answer any questions, and have fully answered any questions from the patient. I believe that this patient fully understands the procedure, and its possible consequences, and has made a fully informed decision to consent to the procedure.

Physician signature: _____ **Date:** ____/____/____