INFORMED CONSENT for TERMINATION OF PREGNANCY, MEDICATIONS AND OTHER MEDICAL SERVICES

Southwestern Women's Options ("the Clinic") is the office of Curtis Boyd, M.D., P.C.

Client Name _____

Birth Date _____

Date _____

I, _____ am asking the doctors of the Clinic to perform a pregnancy termination for me. I understand that the purpose of this procedure is to stop my pregnancy so it will not end in childbirth or to remove a pregnancy from my uterus that is no longer viable. Having this procedure performed is my own decision. No one is threatening me or forcing me to terminate this pregnancy or to have this procedure performed at the Clinic. I made the decision to have this procedure because I believe that it is the best choice for me.

I give my permission for any tests, procedures or medications that the Clinic doctors think I should have either for my pregnancy termination or for care of any complications that may occur. I give my permission for the Clinic doctors or staff to give me whatever medications they believe necessary for the safe completion of my termination of pregnancy.

I do NOT give my permission for the following procedure (s) to be performed or medication (s) to be administered. (Please write "N/A" if this is not applicable)_____

_____.

The information I have given the Clinic about my medical history is true. I have included in my medical history significant illnesses, surgeries, pregnancies, drug use, medication use, allergies, bad reactions to any medication, or any other medical facts about me. The Clinic doctors can rely on my medical history as being true and complete.

I understand that the age of my pregnancy is determined by my medical history and ultrasound measurements taken here in the clinic. Based on this information, the doctors will recommend what method they will use for my pregnancy termination. I give my permission for them to use the method of termination that they think is best.

I understand that the pregnancy tissue will be removed from my body during this procedure. The pregnancy tissue may be examined here in the Clinic and the Clinic doctors may dispose of the tissue according to the law.

I understand that the medications used during my pregnancy termination may not eliminate all pain. I know I could have a bad reaction to any of the medications administered by the Clinic. A bad reaction could be minor or severe. If I have a bad reaction, the doctors and staff may treat it as medically necessary, which may include calling emergency services for transfer to a hospital.

I understand that complications may occur as the result of any medical procedure, including a termination of pregnancy, even if the doctor does everything right. The risk of complications related to a termination of pregnancy increases as the pregnancy advances. This means an earlier procedure is less likely to result in complications than a later procedure. Complications can be small or very serious. They could even result in death. Termination of pregnancy has fewer complications than childbirth and when something does go wrong in this procedure it is usually less serious than a complication of childbirth. If I experience a complication while at the Clinic, the doctors and staff may treat it as medically necessary, which may include calling emergency services for transfer to a hospital.

No guarantee has been made to me about the outcome of this termination of pregnancy.

Initials_____

For women who have had one or more prior Cesarean sections:

Uterine rupture: I understand that having a Cesarean section ("C-section") scar places me at extra risk for any procedure related to pregnancy including abortion and childbirth. The further along in my pregnancy I am, the more risk I have from my C-section scar. I understand that having an abortion is safer for my health than carrying the pregnancy to term. One serious possible complication that results from having a C-section is uterine rupture. Uterine rupture occurs when the muscle wall of the uterus tears open. The chance of a uterine rupture happening is approximately 1% during childbirth. It is less likely to happen during an abortion. The risk of uterine rupture occurring increases as the pregnancy grows. Uterine rupture may result in bleeding which may require blood transfusions, major surgery and/or could result in death. Uterine rupture also may result in me requiring a hysterectomy. A hysterectomy is the total removal of my uterus, which would make it impossible for me to get pregnant again.

I understand that my physician and/or counselor will answer any questions or concerns I have, and I will ask such questions before leaving the clinic. If I have concerns or complications after leaving, I agree to call the Clinic immediately.

If the physician asks me to do so I agree to have an examination and pregnancy test in two (2) weeks after the abortion, in order to rule out a continued pregnancy or the existence of other problems. If I fail to schedule and/or attend the recommended post-procedure examination, I release the Clinic, attending physicians, and staff from any liability or responsibility for injuries and/or damage caused by the failure to treat timely any complications related to the termination procedure.

I UNDERSTAND THAT, WHEN POSSIBLE, I MAY BE TREATED FOR ANY RESULTING COMPLICATIONS AT DR. CURTIS BOYD'S OFFICE, AT NO CHARGE TO ME; HOWEVER, SHOULD HOSPITALIZATION BE NECESSARY, I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY CHARGES.

I further understand that the medical practice of my physician(s) at Curtis Boyd. M.D., P.C. is to be judged according to those standards reasonably acceptable to other physicians practicing in similar facilities in the Unites States.
I certify that I have read, had explained to me, and fully understand the above informed consent, and that I agree, in light of the consent, to the pregnancy termination procedure I have requested.

Date _____

Signature of Client _____

Witness - Staff Person _____

Provider signature_____