This is an example of the kind of consent form you might be asked to sign at an abortion clinic.

The purpose of a consent form is to give you information about some of the very rare risks and possible complications of the procedure you are requesting.

Although it is very important for you to have this information, it can be scary to read about problems that are unexpected. Imagine if you had to sign a consent form telling you all the things that could happen on your drive to the clinic. You wouldn't want to leave the house!

Please do not sign the consent form and request an abortion unless you are emotionally resolved and confident of your decision. Initial the box to indicate that you understand and have had all your questions answered.

Rainbow Women's Clinic
Consent Form

Initials

☐ **1.** I know that my choices with this pregnancy are to have an abortion or have a baby. If I have a baby, I can place for adoption.

☐ **2.** I understand that the purpose of the abortion I am requesting is to end the life of this pregnancy, and remove the embryo/fetus from my body. It is my own choice to do this, and no one has forced me to make this decision.

☐ **3.** I request and consent to an abortion by vacuum aspiration or dilation and evacuation (depending on the method the physician deems appropriate for the length of pregnancy) at the Rainbow Women's Clinic, by Dr. Johnson. I consent to any tests or procedures which my medical attendants find necessary or advisable in the course or evaluation or treatment.

☐ **4.** I understand the explanation I have been given for how the abortion will be done.

☐ **5.** I understand that the abortion will be done using a local anesthetic, which will not eliminate all pain, and that, in rare cases, there could be severe reactions to local anesthetics, including shock. I consent to the doctor or associates giving me anesthetics or other medications which may be thought necessary or advisable, except the following to which I am allergic:

_____

☐ **I am not allergic to any medications that I know of.**

☐ **6.** I understand that the embryo/fetus will be removed during the abortion, and I agree to the examination and disposal of the tissue in a manner deemed correct by the physician, in accord with the law.

☐ **7.** If complications happen during my abortion I authorize my medical attendants to perform any other procedures and to give medications thought to be needed for my well being; or to transfer me to the hospital for emergency care. I understand that my emergency contact (my parents if I am under 18) would be notified.

☐ **8.** I understand that no medical procedure, including abortion, can guarantee successful results. I understand that rare, but possible, complications of abortion include but are not limited to:

. Infection

. Incomplete abortion or clots in the uterus, which could require a repeat of the procedure

. More bleeding that expected

. Perforation (break or tear) in the uterus. Usually self-repairing.

. Continuing pregnancy
. Damage to the uterus or nearby internal organs, which could result in the loss of the ability to have a baby in the future.
. Emotional/psychological problems requiring professional help.
. Death

☐ **9.** I understand that I may be treated for minor complications at the clinic within one month of my abortion at no additional charge. However, I understand that I am responsible for the cost of any hospitalization or doctor's care other than at the clinic.

☐ **10.** I understand that my doctor and other staff need complete and honest information about my medical history. I have given the date of my last period as accurately as I can; I have completed the medical history form accurately; and I have reported any drugs or medications I have taken, and any medical problems including:

. Allergies or bad reactions to any medications
. Asthma or chest pains
. Anemia or bleeding/clotting problems
. Heart disease
. High blood pressure or circulatory problems
. Alcohol or drug problems
. Epilepsy
. Pelvic Inflammatory Disease (uterine infection) or STI's
. Rheumatic fever

☐ **11.** I agree to have an examination 2-3 weeks after my abortion to check for continuing pregnancy and complications. I agree to follow the instructions for care after my abortion, and to contact the clinic with questions or any problems including:

. Fever of 100 degrees or higher (chills, aching, fatigue)
. Abdominal cramping or pain more severe than with a period
. Bleeding heavier than a period, or lasting longer than 3 weeks
. Vaginal discharge that is unusual or bad smelling
. Allergic reaction (such as a rash) or difficulty breathing
. Passing large or numerous clots

. Severe or persistent feelings of regret or depression

I understand that if I am having problems it is my responsibility to seek prompt treatment in order to avoid more serious complications.

☐ **12.** I understand that the medical practice of my physician and other attendants is to be evaluated according to the generally accepted standards of practice used by other physicians in similar facilities in the county and state. I understand my doctor makes no guarantees as to result, but agrees to use her/his best judgment.

☐ **13.** If I seek emergency care or medical care with another doctor or clinic, I understand that information about my treatment at the Rainbow Women's Clinic may be shared at your request.

☐ **14.** If I have chosen to start birth control pills, I understand that possible side effects include: severe headaches, leg cramps, blurred vision, chest pains, blood clots, and stroke. I will report pill side effects to the clinic or my own doctor/clinic as soon as possible.

Please wait to sign this form with your counselor

Print your name

Signature

Date