

CLIENT INFORMATION SHEET

Last Name		First Name		MI
Address				
City		State	Zip	
Preferred Phone #	Type of phone (Circle one) Home Work Cell Pager Other _____		Alternate Phone #	Type of phone (Circle one) Home Work Cell Pager Other _____
How should we identify ourselves when calling (Circle one) Planned Parenthood "Your Dr's Office" Other: _____				
Type of envelopes we should use for mailings (Circle one) Planned Parenthood Logo Plain Envelope				
Social Security Number		Date of Birth	Gender (Circle one) Male Female	
Primary Care Physician (PCP)			PCP Telephone #	
Emergency Contact Information				
Emergency Contact Name	Relationship to You		Emergency Contact Phone #	Type of phone (Circle one) Home Work Cell Pager Other
Race Information				
What is Your Race? (Check one or more)				
<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American		
<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Pacific Islander		
Hispanic Origin? (Circle one) Yes No				
Primary Language	Secondary Language	Marital Status Single Married Divorced		
PRIMARY INSURANCE				
Insurance Name		Policy Holder (Circle one) Self Dad Mom Spouse Other: _____		
Policy Holder's Name (If other than self)		Policy Holder's Address (If other than self)		
Policy Holder's Date of Birth	Policy Holder's Social Security Number		Policy Holder's Employer	
SECONDARY INSURANCE (Fill in only if you have another insurance)				
Secondary Insurance Name		Policy Holder (Circle one) Self Dad Mom Spouse Other: _____		
Policy Holder's Name (If other than self)		Policy Holder's Address (If other than self)		
Policy Holder's Date of Birth	Policy Holder's Social Security Number		Policy Holder's Employer	

I certify that the above information is true, correct and complete to the best of my knowledge. I hereby assign to Planned Parenthood of Maryland (PPM) the right to any claim or reimbursement for medical services provided by their physicians and clinical staff. I understand that I am responsible for any fees which are rejected by my insurance company and for which PPM received no payment. I also permit the copying and release of medical records to the insurance company for the processing of claims related to services provided. I understand that PPM is required to report to the appropriate government agencies if they suspect I am currently the victim of child abuse or neglect or if I indicate I was a victim of child abuse or neglect when I was a minor, even if I am now over age 18.

Client Signature: X _____ **Date:** _____

Present Photo ID, Insurance Card and/or Proof of Income to Front Office Staff

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

Abortion Medical History & Lab Record

GENERAL HISTORY		HOSPITALIZATIONS / SURGERIES	
What is your age? _____		Year	Reason
Yes	No		
		GYN HISTORY	
		Yes	No
			Are you allergic to: <input type="checkbox"/> latex <input type="checkbox"/> iodine <input type="checkbox"/> medication (please list) _____
			Are you taking any medications? If yes, please list: _____
			Do you smoke cigarettes, cigars, pipes, or chew tobacco? If yes, how much per day? _____
			Are you breastfeeding now?
			Do you take antibiotics before seeing the dentist?
MEDICAL HISTORY		SEXUALLY TRANSMITTED INFECTION (STI) HISTORY	
Yes	No	Have you ever had any of the following?	Yes
		High blood pressure	No
		High cholesterol / triglycerides	
		Breast mass / cancer	
		Heart attack/disease/murmur/mitral valve problem	
		Family history of heart attack or stroke before age 55	
		A stroke or blood clots in your legs or lungs	
		Bleeding problems / sickle cell anemia / inherited porphyrias	
		Migraine headaches *	
		Seizures / epilepsy	
		Liver disease/ jaundice/ hepatitis/ gall bladder problem	
		Diabetes	
		Osteoporosis/fragility fracture	
		Asthma	
		Drug or alcohol use	
		Depression / anxiety / bi-polar / eating disorder	
			Have you had more than one sexual partner since your last STI testing?
			Have you had a new sexual partner since your last STI testing?
		OTHER	
		Please list other medical problems:	
		CLIENT SIGNATURE	
		TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.	
		Signature: x _____	Date: _____

*** Staff Use Only ***

LMP _____ G _____ Vag _____ C/S _____ TAB _____ SAB _____ Other _____ Contraception _____

LABORATORY EVALUATION
Hb _____ Rh _____ PT _____ BP _____ P _____ Height _____ Weight _____ BMI _____

LITERATURE PROVIDED
 PPMFS 065 CI: Rh(o) Immune Globulin (given if Rh negative)
 PPMFS 165 CI: Dietary List of Iron Rich Foods

STI TESTING
Y N
 Pt < 26 yo or screens "yes" for STI testing
If yes to above:
 Pt desires STI testing
 Specimen collected

SONOGRAM TV _____ TA _____ Y N
GS _____ GA** _____ Pt informed of ultrasound limitations
CRL _____ GA** _____ Pt wants to see ultrasound image
BPD _____ GA** _____ Pt given copy of ultrasound image
FL _____ GA** _____ Pt wants to know if twins present
Fetal # _____ Placental location _____ (≥14 wks)
Cardiac activity yes no

** Gestational age calculated by ultrasound

COMMENTS: _____

Staff Signature/Date: _____ Clinician Signature/Date: _____

Client Information for Informed Consent

IN-CLINIC ABORTION Suction

What is an in-clinic suction abortion?

An in-clinic suction abortion (also known as a D&C or surgical abortion) ends your pregnancy. During the abortion suction is used to take out the contents and lining of your uterus (womb). The way the abortion is done depends on how long you've been pregnant. This is figured out by counting from the first day of your last period or by an ultrasound.

Before having an abortion, you need to know the most common benefits, risks, side effects, emotional reactions, and other choices you have. We are happy to answer any questions you have.

What are the benefits of abortion?

- It is a safe and effective way to end a pregnancy.
- At some Planned Parenthood clinics, you may be able to donate your pregnancy tissue for medical research.

What are the side effects of abortion?

Side effects don't usually last long and don't need to be treated. Call us if the problem doesn't go away or you are worried. Common side-effects are:

- light or medium bleeding. If your bleeding is very heavy — soaking more than 2 maxi pads for 2 hours in a row, contact us.
- cramping
- feeling tired (usually from anesthesia and/or pain medications)

What are the emotional reactions to abortion?

Having a wide range of emotions is normal with abortion. Most women feel relief and do not regret their decision. Others may feel sadness, guilt, or regret after an abortion, just as they may after having a baby. If you are not able to do what you usually do or are feeling bad after 2 weeks, call us. We can help or send you to someone who can.

Besides an in-clinic abortion, what other abortion options do I have?

If you are less than 9 weeks pregnant, you may be able to use the abortion pill. You can also be sent for an abortion in a hospital or by another doctor, now or later in your pregnancy. But, there are more risks the longer you wait to have an abortion.

What are the risks of abortion?

Abortion is very safe. But, there are risks with any medical procedure. The risks increase the longer you are pregnant and if sedation or general anesthesia is used. Your overall health affects your risk of complications. Your risk is higher if you are in poor health. Your risk for complications may be higher if you have had a c-section, uterine or abdominal surgery. **Risks linked with abortion using suction are:**

- **Incomplete abortion** — Pregnancy tissue left inside the uterus (womb) may lead to heavy bleeding, infection, or both. If this happens, the suction procedure may need to be done again at a clinic or hospital. Other tests or treatments may be needed.
- **Blood clots in the uterus** — Clots may cause cramping and abdominal pain. The suction may need to be done again.
- **Infection of the uterus** — Most infections can be found and treated with medicines. But, there is a small chance that the suction may need to be done again. You may have to go to the hospital, or even have surgery to treat the infection.
- **Failure to end the pregnancy** — Sometimes the abortion does not end the pregnancy. If the pregnancy is still in the uterus, more suction may be needed. If the pregnancy is ectopic (outside the uterus), it requires urgent medical attention. Some women may need medicine and others may need surgery.
- **Heavy bleeding (hemorrhage)** — This may require treatment with medicine, another suction, blood transfusion, and/or surgery — including possible hysterectomy (removal of the uterus).
- **Injury to the cervix (opening to the uterus)** — A cervical tear may be treated with medicine or rarely with surgical stitches in the cervix.
- **Injury to the uterus or other organs** — A surgical tool may go through the wall of the uterus, which could damage internal organs such as the intestines, bladder, or blood vessels. Treatment may consist of observation or abdominal surgery. There is a risk that hysterectomy (removal of the uterus) may be needed. Scar tissue may develop inside the uterus which may require treatment.
- **Allergic and/or drug reaction** — Some women may be allergic to the local anesthetic or to other medicines used. It is important that you tell us about all medicines you are allergic to. Also tell us about any medicines you are taking. We need to be sure they do not mix badly with medicines we give you.
- **Death** — Death from a suction abortion is very rare. But, the risk of death from an abortion increases the longer you are pregnant. When an abortion is done when a woman is less than 20 weeks pregnant (about 4 ½ months), the risk of death from a full-term pregnancy or childbirth are higher. After 20 weeks of pregnancy the risks are about the same.

What will be done to get me ready for the abortion?

Education and Consent — A staff person will:

- talk to you about your medical history
- tell you about the abortion
- answer any questions you have
- get your written consent (permission) for you to have the abortion

Laboratory Tests — You will get:

- a pregnancy test
- a blood test to check your Rh type
- a blood test to see if you have anemia (low iron)
- other tests your doctor thinks you need

Ultrasound — You may need an ultrasound. It can help tell how long you've been pregnant. A probe (like a wand) will be placed on your abdomen (belly) or into your vagina to get a picture of the pregnancy.

Physical Exam — You will have your blood pressure taken and have a pelvic exam. You may get other exams if your doctor thinks you need them.

Review — A doctor will talk to you about your medical history, exams, and any tests you had to decide if the abortion can be done at Planned Parenthood.

Pain Medicine — A staff person will tell you about pain medicines that can be used. You will be given written instructions to read and sign if you are going to get medicine to make you relaxed, drowsy, or sleep during the abortion.

Opening (dilating) your cervix — Your cervix may need to be opened (dilated) before your abortion. If so, you will be given separate information about the medicine and/or steps that will be taken to open (dilate) your cervix.

What should I do the day before my abortion?

The day before your abortion you should:

- Buy maxi pads and pain medicine (e.g., ibuprofen/Advil or acetaminophen/Tylenol) to use afterwards.
- Plan for your family or friends to help you.

What will happen to me during my abortion?

You will be given pain medicine. You probably will get medicine to numb your cervix. You and your doctor will decide what other medicines you will need to help with your pain and discomfort during your abortion.

After your pain medicine begins to work, your doctor will decide if your cervix is ready (open enough). If your cervix needs to be dilated (opened) more, your doctor will stretch it with dilators.

What will happen to me during my abortion?

When your cervix is stretched open enough, the contents of your uterus (womb) are taken out with suction. Suction is used by putting a small plastic tube into your uterus and connecting it to a hand-held syringe or electric suction machine. Surgical tools may be put into the uterus through the cervix. The way it is done will depend on how long you've been pregnant.

You may feel cramping during and after the abortion as your uterus shrinks back to its smaller size. Your doctor may also use a curette (a narrow surgical tool) to remove any remaining tissue. The tissue will be carefully looked at to help make sure the abortion is finished.

What will happen to me after my abortion?

You will be taken to a recovery area for rest. We will also watch to see if you are OK. You will be given instructions on what to expect and how to care for yourself. We will talk about birth control plans with you, unless this was already done.

When you feel comfortable, usually after 30 minutes or so, you may leave. You may need someone to drive you home. This may be required depending on if you had medicine to sedate you during the abortion.

What else do I need to know?

You will be given instructions on caring for yourself after your abortion and information on when to come back to us if you are having a problem.

It is important that you understand the possible risks, side effects, and complications, as well as other choices you have. No promise can be made about the outcome of your abortion. In the unlikely event that you need emergency medical care that cannot be provided at Planned Parenthood, you will be responsible for paying for it. This is the case even if Planned Parenthood sends you to a hospital because of a complication.

Your health is important to us. If you have any questions or concerns, please call us at **1-877-994-6432**. We are happy to help you.

X _____
Client Signature

Date

The patient got this information. She said she read and understood it. She was able to ask any questions she had.

Witness Signature

Date



Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

VOLUNTARY REQUEST FOR SURGERY OR SPECIAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

<input type="checkbox"/> IUC insertion/removal	See CIIC: Intrauterine Contraceptives (IUCs) [or Removal of]
<input type="checkbox"/> Colposcopy with biopsies	See CIIC: Colposcopy and Cervical Biopsy
<input type="checkbox"/> Implanon insertion/removal	See CIIC: Single-Rod Implant (Implanon) [or Removal of]
<input type="checkbox"/> Vasectomy	See CIIC: Vasectomy
<input type="checkbox"/> In-Clinic abortion	See CIIC: In-Clinic Abortion
<input type="checkbox"/> Abortion pill	See CIIC: Using the Abortion Pill
<input type="checkbox"/> Misoprostol—second dose	See CIIC: When the Abortion Pill Doesn't Work—Taking a Second Dose of Misoprostol
<input type="checkbox"/> Moderate sedation	See CIIC: Moderate Sedation
<input type="checkbox"/> Treatment of miscarriage	See CIIC: Treatment of Miscarriage by _____
<input type="checkbox"/> Other _____	See _____

I have been given information about the test(s), treatments, service(s)/procedure(s)/ surgery to be provided, including the benefits, risks, possible problems/complications and alternate choices. I was given *written patient information* and/or a copy of the Planned Parenthood Client Information for Informed Consent sheet. It was reviewed with me.

I understand that with any service/procedure/surgery, there is also the possibility of side effects. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee about the results from this service/procedure/surgery has been given to me. I know that it is my choice whether or not to have this service/procedure/surgery. I know that I can change my mind about receiving this service at Planned Parenthood at any time.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

If there is an unexpected complication during the service/procedure/surgery, I request and authorize the clinician and authorized Planned Parenthood staff to do whatever is necessary to preserve my health and welfare.

In the event I need more pain medication to safely continue or complete the procedure, I request and authorize Planned Parenthood staff to give me medications they believe necessary. This may include medications to reduce pain and/or anxiety. I understand every medication carries a small risk. I understand the clinician will only use medications if s/he believes it is clinically indicated.

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

I request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it) and perform the service(s)/ procedure(s)/surgery listed above.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I understand that confidentiality will be maintained as described in [NAME OF AFFILIATE'S] *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby acknowledge receipt of Planned Parenthood of Maryland's notice of health information privacy practices.

Signature of Client **X** _____ Date _____

I witness the fact that the client received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of Witness _____ Date _____

CHECK HERE IF CLIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting **X** _____

Relationship to client _____

Date _____

I witness the fact that the client's legal guardian (or person consenting in her/his behalf) received the above mentioned information and said she/he read and understood same.

Signature of Witness _____

Date _____