

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: _____



Annapolis: 410.263.2100
Frederick: 301.662.7171
Towson: 410.665.9775

Baltimore City: 410.576.1414
Owings Mills: 410.363.1655
Waldorf: 301.645.6800

Easton: 410.820.9067
Salisbury: 410.860.4788

Client Information for Informed Consent

IN-CLINIC ABORTION Suction

Before having an abortion, you need to know the most common benefits, side effects, risks, and alternatives. We have listed them here for you. We are happy to answer any questions you have.

A suction abortion ends a pregnancy by suctioning away the contents of the uterus. The way it is done may depend 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.

Care Before Abortion

Education and Consent — A staff person will

- Review your medical history.
- Explain the procedure.
- Answer any questions.
- Obtain your written consent.

Laboratory Tests — Tests may include

- a pregnancy test
- a blood test to check your Rh type and to see if you have anemia (low iron)
- other tests your clinician may advise

Ultrasound — You may need an ultrasound. It can help tell how long you've been pregnant. If an ultrasound is needed, a probe will be passed over your abdomen 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. Additional examination may also be done if necessary.

Review — A doctor will review your medical history, exam, and any tests taken to determine if the abortion can be performed at Planned Parenthood.

Pain Medication — A staff person will discuss and offer options. We will give you written instructions to read and sign if you are going to have medication to make you relaxed, drowsy, or sleep during the procedure.

Cervical Preparation — Your cervix may need to be prepared before the procedure. If so, you will be given separate information about the medication and/or treatments that will be used.

Prepare Ahead — The day before your procedure

- Buy maxi pads and pain relievers, e.g., ibuprofen (Advil) or acetaminophen (Tylenol) to use afterwards.
- Arrange for help from your family or friends.

The Abortion Procedure

We will give you pain medication. It may include a local anesthetic (to numb the cervix, the opening to the uterus) or other medications that you and your clinician have decided upon to decrease pain and discomfort during the procedure.

After your pain medication begins to work, the clinician will decide if your cervix is ready. The clinician will gradually stretch the opening of the cervix with narrow instruments called dilators. When the cervix is stretched open enough, a small plastic tube is inserted into the uterus. It is connected to a hand-held syringe or to an electric suction machine. The tip of the tube is moved around inside of the uterus for a few minutes in order to remove the pregnancy tissue from the uterus.

You may feel cramping during and after the procedure as the uterus shrinks back to its smaller size. The clinician may also use a curette, a narrow spoon-shaped instrument, to remove any remaining tissue. The tissue will be examined to help make sure the procedure is complete.

After the Abortion

You will be taken to a recovery area for rest and observation. You will be given instructions on what to expect and how to care for yourself. You may be scheduled for an appointment in two weeks. Birth control plans will be discussed with you, unless this was done earlier in the visit. When you feel comfortable, usually after 30 minutes, you may leave. You may need someone to drive you home. This may be required if you had medication to sedate you during the procedure.

Benefits

Vacuum aspiration is a safe and effective way to end a pregnancy. At some Planned Parenthood sites, you may have the option to donate pregnancy tissue for medical research.

Side-Effects

Side-effects are usually temporary and require no treatment. Call us if they become problems and continue or you are concerned. Common side-effects include

- bleeding
- cramping
- fatigue (usually from anesthesia and/or pain medication)

Emotional reactions — 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 giving birth. If you are not able to do your normal activities or are feeling bad after two weeks, call us. We can help or refer to someone who can.

Risks — Suction abortion is very safe. However, 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 is another factor that affects your risk of complications. Your risks increase if you are in poor health. Your risks for complications may increase if you have had a c-section, uterine or abdominal surgery. Risks include

- Incomplete abortion — Pregnancy tissue left inside the uterus may lead to excessive bleeding, infection, or both. If this occurs, the abortion may need to be repeated in a clinic or hospital. Other tests or treatment may be necessary.
- Blood clots in the uterus — Clots may cause cramping and abdominal pain. The abortion may need to be repeated.
- Infection of the uterus — Most infections are easily identified and treated with

medications. However, there is a small chance that repeated abortion, hospitalization, or even surgery may be necessary to treat the infection.

- Failure to end the pregnancy — Sometimes the abortion fails to end the pregnancy. If the pregnancy is in the uterus, repeated abortion is recommended. If the pregnancy is ectopic (developing outside the uterus), it requires immediate medical attention. Some cases may be treated with medication; others may require surgery.
- Excessive bleeding (hemorrhage) — This may require treatment with medication, repeated abortion, blood transfusion, or surgery — including possible hysterectomy (removal of the uterus).
- Injury to the cervix — A cervical tear may be treated with medicine or rarely with surgical stitches in the cervix.
- Injury to the uterus or other organs — An instrument 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 of hysterectomy (removal of the uterus). Scar tissue may develop inside the uterus which may require treatment.
- Allergic reaction — Some women may be allergic to the local anesthetic or to other medications used. All medicine and drugs may cause serious reactions alone or with anesthesia. It is important that you tell your clinicians about all drugs you are allergic to or are taking.
- Death — Death from a suction abortion is very rare. However, the risk of death during or after abortion increase the longer you are pregnant. The risk of death from a full-term pregnancy and childbirth is much greater than abortion.

You will be given instructions on caring for yourself after the abortion and a telephone number to reach the clinic if you have a problem. You will also be asked to return to Planned Parenthood for a follow-up visit.

No guarantee can be made about the outcome of the abortion procedure. It is important that you understand the potential risks, side-effects, and complications, as well as alternatives to the procedure. 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 — even if Planned Parenthood refers you to a hospital because of a complication.

Options

There are alternatives to an in-clinic abortion. If you are early in your pregnancy, you may be eligible to use medicines to end the pregnancy (this is using the abortion pill). Other alternatives include a referral for an abortion in a hospital or by another provider now or later in the pregnancy. However, the risks of the procedure become greater the longer you delay an abortion.

There are alternatives to abortion. The three options for women who become pregnant are parenthood, adoption, and abortion.

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.

Client signature _____ Date _____

I witness the patient received this information, said she read and understood it, and had an opportunity to ask questions.

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.

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

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.

I understand that confidentiality will be maintained as described in Planned Parenthood of Maryland'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*.

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.

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 following service(s)/ procedure(s)/surgery:

<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"/> Other _____	See _____

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

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 _____