Planned Parenthood® of Maryland, Inc.

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 Name	Relationship to You	Emergency Contact Phone #	Type of phone (Circle one) Home Work Cell Pager Other

What is Your Race? (Check one or more)

	American Indian		Asian		Black/African American
	Alaskan Native		White		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

Planned Parenthood®
of Maryland, Inc.

Affix Label Here

Client's Name: ______________________________

DOB: ________________ Date: ________________

Abortion Medical History & Lab Record

GENERAL HISTORY		
What is your age?________		
Yes	No	
		Are you allergic to: □ latex □ iodine □ 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		
Yes	No	***Have you ever had any of the following?***
		High blood pressure
		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

HOSPITALIZATIONS / SURGERIES	
Year	Reason

GYN HISTORY		
Yes	No	
		Have you had uterine surgery (e.g., to remove fibroids)?
		Have you ever had an abnormal pap smear? If yes, date of abnormal pap: _____________ Treatment: □ Cryotherapy □ LEEP □ None Date of most recent pap: ____________
		Other genital trauma or surgery? List: ____________________

SEXUALLY TRANSMITTED INFECTION (STI) HISTORY		
Yes	No	
		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 ____

GS ___________________ GA** ___________

CRL ___________________ GA** ___________

BPD ___________________ GA** ___________

FL ___________________ GA** ___________

*** Gestational age calculated by ultrasound*

Y N

□ □ Pt informed of ultrasound limitations

□ □ Pt wants to see ultrasound image

□ □ Pt given copy of ultrasound image

□ □ Pt wants to know if twins present

Fetal # ________ Placental location ____________(≥14 wks)

Cardiac activity □ yes □ no

COMMENTS:____

____

Staff Signature/Date: ____________________________ Clinician Signature/Date: ____________________________

** Give client Headache Questionnaire.*

(Attach photo to back)

Planned Parenthood®
of Maryland, Inc.

Annapolis: 410.263.2100 | Baltimore City: 410.576.1414 | Easton: 410.820.9067
Frederick: 301.662.7171 | Owings Mills: 410.363.1655 | Salisbury: 410.860.4788
Towson: 410.665.9775 | Waldorf: 301.645.6800

Client Information for Informed Consent

USING THE ABORTION PILL

Before you have the 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.

"Abortion pill" is a popular name for a medicine called mifepristone. (Mifeprex® is the brand name.) It ends the pregnancy. It does this by keeping your body from making a certain hormone called progesterone. The pregnancy cannot go on without progesterone.
After you take the abortion pill, you will take a second medicine called misoprostol. It opens the cervix and makes the uterus contract. This empties the uterus and completes the process. The whole process is called medication abortion.

There are different ways to take these medicines. There is the way approved by the FDA. The FDA way is talked about in the Medication Guide and Patient Agreement. You will read these papers. You will need to sign the Danco Patient Agreement to show that you understand the FDA way. Alternative ways to take the medicines have been studied. They are also safe and effective. By choosing one of the alternative ways, you will take the abortion pill (Mifeprex®) in the office. Then you take the misoprostol pills at home. We will give you instructions, "How to Take Your Pills." It is important to follow these instructions. The amount and timing of the pills used is different from the FDA way.

Benefits — Using the abortion pill together with misoprostol is safe and effective. At Planned Parenthood, it has worked about 98 out of 100 times. Women can use it in the first nine weeks (63 days) of pregnancy.

Side-Effects — They usually do not last long. They usually need little or no treatment.

- **Cramping is expected —** It will be most severe after you take the misoprostol. Milder cramps may last a day or two after that.
- **Bleeding is expected —** It will be heaviest soon after taking the misoprostol. You may bleed or spot for three to four weeks after the abortion. You can expect your next period in four to eight weeks.
- **Fever —** Having a temperature of 99-100°F is okay. It should only last a short time.
- **Other —** It is common to have diarrhea, nausea, vomiting, headache, dizziness, back pain, and tiredness. They usually lighten up three days later. They usually stop within two weeks.

Emotional reactions — A wide range of emotions is normal with abortion. Most women feel relief and do not regret their decision. Some women may feel sadness, guilt, and/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 you to someone who can.

Risks — Using the abortion pill together with misoprostol is safe and effective. But there are risks with any medical procedure. Your risk depends on how healthy you are. If you are in poor health, your risk goes up. These are the possible risks of using this procedure:

- **Failure to end the pregnancy —** Sometimes the medicines do not end the pregnancy. But they may cause serious birth defects. You may need to take additional medicines or have an abortion in a clinic or a hospital if the pregnancy continues.
- **Incomplete abortion —** Sometimes some of the contents of the uterus are not emptied. This can cause too much bleeding, infection, or both. You may need an abortion in a clinic or a hospital if that happens. You may also need other tests or treatments.

- **Blood clots in the uterus —** Clots in the uterus may cause cramping and pain. You may need a surgical procedure if that happens.
- **Bleeding too much or too long —** To make it stop, you may need treatment. It might include medication or a suction procedure. In some cases, a blood transfusion is needed.
- **Infection —** Most infections are easy to treat with medicine. But there is a small chance that you may need an abortion in a clinic, to go a hospital, or to have surgery.
- **Allergic reaction —** Some women are allergic to the medicines that are used. Any medicine or drug can cause a serious reaction when used alone or with something else. It is important for you to let us know all the drugs that you are taking or that you are allergic to. This includes herbal drugs.
- **Death —** Death from medication abortion is very rare. The risk of death from a full-term pregnancy and childbirth is much greater.

Call us right away if you have:

- **Abdominal pain —** This includes feeling sick, being weak, having nausea or diarrhea, or throwing up. It should not last longer than 24 hours after you take the second medicine. Call us right away if they do. Any one of them may be a sign of a serious infection. Or it could be another problem, like ectopic pregnancy. (That is a pregnancy that grows outside the womb.)
- **Heavy Bleeding —** Call us right away if you soak through two thick, full-size sanitary pads every hour for two hours in a row. Or call us if you think your bleeding is too heavy. One out of every 100 women bleed so much that that they need a surgical procedure to stop it.
- **Fever —** Call us right away if you have a fever of 100.4°F or more if it lasts for four hours and it happens during the few days after you take the second pills. Fever that high can be a sign of serious infection. Or it could be another problem, like ectopic pregnancy.

We will give you instructions on how to take care of yourself during the abortion. We will give you a special telephone number to reach us if you have a problem. We will give you a time to return to Planned Parenthood for a follow-up visit.

The outcome of a medication abortion cannot be guaranteed. It is unlikely that you will need emergency medical care that cannot be provided at Planned Parenthood. If you do, however, you will be responsible for paying for it — even if Planned Parenthood refers you to another doctor or hospital because of a medical problem.

Options

There are two alternatives to abortion. They are parenthood and adoption. We can discuss any of these options with you. And we can help you with whatever decision you make.

There are alternatives to using the abortion pill. You can have the abortion done in a clinic. You can have it done in a hospital. Or you can go to another provider. You can have the abortion now or later in the pregnancy. But your risks get bigger the longer the abortion is delayed.

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 that the client 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.

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