

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

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.

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 _____