

PLANNED PARENTHOOD GREATER MEMPHIS REGION

DEMOGRAPHIC DATA

Today's Date: _____ CHART NUMBER _____

Birthdate: _____

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Age: _____ SSN: _____

Sex: F / M Home Phone: _____ Cell Phone: _____ Wk Phone: _____

Race: White Black Native American Asian Pacific Islander Other	Ethnicity: Hispanic Non-Hispanic
Marital Status: Married Single Divorced Partnered	Education Level: _____
Occupation: _____	Employer: _____

How did you hear about us? (Please choose one)			
1-Other Clinic	2- Hospital/health agency	3-Private Doctor	4-Social/Church Agency
5-School	6-Other Patient	7-Family/Friend	8-Media
9-Hotline	10-Phonebook	11-Other Public Health Program	

Pregnancy Information:
Number of Pregnancies: _____
Number of Births: _____
Number of Living Children: _____

Emergency Contact:
Who should we contact in case of an emergency ONLY?
Name: _____
Relationship: _____ Phone: _____

<u>LAB TEST RESULTS – MUST BE COMPLETED</u>
Planned Parenthood MUST be able to contact you in certain situations. We also want to protect your privacy and confidentiality. If it is necessary to reach you for abnormal test results, what do you want us to say when calling ? <input type="checkbox"/> Planned Parenthood OR <input type="checkbox"/> Dr's Office OR <input type="checkbox"/> Heather
What do you want us to say if we call your work number? <input type="checkbox"/> Planned Parenthood OR <input type="checkbox"/> Dr's Office OR <input type="checkbox"/> Heather
Can we mail a letter to you asking that you contact us? <input type="checkbox"/> Yes <input type="checkbox"/> No
Can the envelope have Planned Parenthood's return address on it? <input type="checkbox"/> Yes <input type="checkbox"/> No

If you DO NOT wish to be contacted at the above address and phone number: Who can we contact? _____ Relationship to you: _____ Their address: _____ Their phone: _____
We reserve the right to send a certified letter to the address you have given if that is the only way we can notify you of abnormal test results.

Place Patient Label Here

Planned Parenthood Greater Memphis Region
1407 Union Suite 300
Memphis, TN 38104
(901) 725-1717

**REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ TELEPHONE # _____

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), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. 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 has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

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 Greater Memphis Region'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 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).

Planned Parenthood Greater Memphis Region
1407 Union Suite 300
Memphis, TN 38104
(901) 725-1717

I hereby acknowledge receipt of Planned Parenthood Greater Memphis Region notice of health information privacy practices.

Signature of patient _____

Date _____

I witness the fact that the patient 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 PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY
REQUIRED TO SIGN BELOW

Signature of any other person consenting _____

Relationship to patient _____

Date _____

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

Signature of witness _____

Date _____

Planned Parenthood Greater Memphis Region
1407 Union Avenue, Suite 300, Memphis, TN 38104 (901) 725-1717

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

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ TELEPHONE # _____

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 Greater Memphis Region'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:

Procedure

Surgical Abortion/ Ultrasound Examination/ RhoGam injection if indicated/ Lab Work

Description of Procedure in Layperson's Language

This has been given in a separate Client Information for Informed Consent sheet

I hereby acknowledge receipt of Planned Parenthood Greater Memphis Region's notice of health information privacy practices.

Signature of Patient _____

Date _____

I witness the fact that the patient 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 PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW.

Signature of any other person consenting _____

Relationship to patient _____

Date _____

I witness the fact that the patient'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 _____

Planned Parenthood Greater Memphis Region

1407 Union Avenue Suite 300

Memphis, TN 38104

(901) 725-1717

Terms of Payment for Surgical Abortion Services

(Please initial in the lines provided, only after you have read each statement)

____ At the beginning of your consultation we will collect an initial fee of \$ 380.00

____ After your sonogram is done the initial charge of \$ 380.00 can change from \$380.00 to \$ 495.00, \$550.00 or \$625.00 according to what the sonogram determines your gestational time (if you are too far for the medical and choose to have the surgical procedure done).

____ Your blood type will be determined in our laboratory. If your RH factor is negative, you will need to purchase a Rhogam shot. The cost of this shot is an additional \$ 50.00 if you are less than 12 weeks or \$125.00 if you are 12 weeks or more, which is due at the time of check-in and cannot be billed to your account.

____ If the medical or surgical procedure is not completed, a fee of \$ 200.00 will be charged to cover for services rendered by our lab and sonogram technician. Any remaining balance will be refunded to you in 14 business days.

By signing this document you acknowledge that you have read and understood our Terms of Payment for Medication Abortion Services Policies and you agree with every term.

Patient Signature: _____ Date: _____

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW
Signature of any other person consenting _____	
Relationship to patient _____	
Date _____	
I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.	
Signature of Witness _____	
Date _____	



**Planned Parenthood Greater
Memphis Region®**

NAME: _____ DATE: _____

To help serve you better, fill out to the best of your ability. Thank you.

1. What decision have you made regarding your pregnancy?

- I'm still undecided
- I want to continue the pregnancy
- I have chosen abortion as my best option

2. On a scale of 1 to 10, was this decision easy or difficult decision (Circle one):

E1 2 3 4 5 6 7 8 9 10D

3. Did you consider any other options? _____

4. Whose decision is it for you to have this abortion? _____

Have you discussed your decision with anyone? _____ If so, who? _____

Are they supportive of your decision? _____

My decision to have an abortion is uncoerced (not forced)? Yes _____ No _____

5. Does the man involved know of your decision? Yes _____ No _____

If so, is he supportive of your decision? _____

6. Circle all the words that describe how you feel:

- Relieved Sad Sure Confident Guilty Calm Confused Happy Numb
- Ashamed Resolved Selfish Angry Peaceful Anxious Disappointed Comfortable
- Irritated Grieving Irresponsible Hopeful Nervous Other: _____

7. What are your thoughts today about ending this pregnancy? _____

8. How do you think you will feel after an abortion? _____

9. Please check what concerns you TODAY (Circle all that apply)

- A. Not sure of decision of having an abortion
- B. Is this confidential?
- C. Your relationship with your partner
- D. Wondering how you'll feel emotionally afterwards
- E. Is this going to hurt?
- F. Possible effects in future pregnancies
- G. Complications during and after
- H. Birth control options
- J. Other _____

10. Have you ever been abused emotionally, physically or sexually? Yes _____ No _____

Staff Comments: _____

- Reviewed alternatives to Abortion (parenting & adoption)
- Discussed risks of surgical abortion (failure, incomplete, infection, hemorrhage, perforation, death)
- Discussed risks of medical abortion (failure, incomplete, infection, hemorrhage, birth defects, death)

Staff/ Counselor Signature

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 will have an ultrasound. It can help tell how long you've been pregnant. 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.

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 901-725-1717. 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 _____



Planned Parenthood Greater
 Memphis Region®

Acknowledge Of Fact Sheets

DATE: _____ PATIENT #: _____

NAME OF PATIENT: _____

DATE OF BIRTH: _____ TELEPHONE #: _____

SURGICAL ABORTION

I have received and read the following fact sheets:

- Early Surgical Abortion
- Ultrasound
- Rh(o) Immune Globulin
- Ativan (Lorazepam)
- Diclofenac
- Aftercare Instructions

Patient Initials

Signature of Patient _____

Date _____

I witness the fact that the patient received the above-mentioned information and said she/he read
 And understand it and had the opportunity to ask questions.

Signature of Witness _____

Date _____

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

Signature of any other person consenting _____

Relationship to patient _____

Date _____

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

Signature of Witness _____

Date _____



Acknowledge Of Fact Sheets

DATE: _____ PATIENT #: _____

NAME OF PATIENT: _____

DATE OF BIRTH: _____ TELEPHONE #: _____

SURGICAL ABORTION

I have received and read the following fact sheets:

- Early Surgical Abortion
- Ultrasound
- Rh(o) Immune Globulin
- Ativan (Lorazepam)
- Diclofenac
- Aftercare Instructions

Patient Initials

Signature of Patient _____

Date _____

I witness the fact that the patient received the above-mentioned information and said she/he read And understand it and had the opportunity to ask questions.

Signature of Witness _____

Date _____

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

Signature of any other person consenting _____

Relationship to patient _____

Date _____

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

Signature of Witness _____

Date _____