

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: _____

How can we contact you? Phone/ Cell Email

Email address: _____

| | |
|--|----------------------------------|
| 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: _____ |



**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.

Procedure/Service

Surgical Abortion/ Ultrasound Examination/ RhoGam injection if indicated/ Lab work
Cervical preparation if indicated and mild sedation

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.

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 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 acknowledge receipt of Planned Parenthood Greater Memphis' 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

**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
2430 Poplar Ave, Suite 100
Memphis, TN 38112
(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 _____

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 **901-725-1717**. We are happy to help you.

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



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? _____

Are you being forced or coerced to have this procedure? 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)
- _____ HIV test offered

Staff/ Counselor Signature _____

revised 11/2/09

Planned Parenthood Greater Memphis Region

2430 Poplar Avenue Suite 100

Memphis, TN 38112

(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 \$ 400.00

____ After your sonogram is done the initial charge of \$ 400.00 can change from \$400.00 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 13 weeks or \$125.00 if you are 13 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: _____

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|---|---|
| | 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:

- In Clinic Abortion
- Ultrasound
- 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 _____