

**PREOPERATIVE INFORMATION CONSENT FORM FOR SURGICAL ABORTION**

I hereby request and consent to have Gabrielle Goodrick, M.D. perform a surgical abortion on me. I fully understand the purpose of this procedure is to terminate my pregnancy. This is my personal decision and no one has coerced me or compelled me to make this decision. After full consideration of all my options including continuing the pregnancy and adoption, I have chosen not to continue the pregnancy.

Signature: \_\_\_\_\_

**Please Initial Below:**

\_\_\_\_\_ I have completely and accurately disclosed my medical history including any health conditions, sexually transmitted infections, known allergies and medications or drugs taken within the last forty-eight hours. I authorize the physician to make medical decisions based upon these disclosures.

\_\_\_\_\_ I consent to the taking and testing of blood samples. I understand these tests are routinely performed and are a necessary component of my care. I understand that the products of conception will be removed during the abortion and I consent to their disposal by Gabrielle Goodrick, M.D. in a manner deemed appropriate.

\_\_\_\_\_ I consent to the administration of intravenous sedation which is intended to control pain and relax me during the procedure. If I receive conscious sedation, as it is commonly called, I may experience drowsiness, fatigue, poor muscular coordination and partial amnesia. I understand that in a small number of women severe reaction or shock may occur requiring emergency care.

\_\_\_\_\_ I understand that all forms of anesthesia involve risks and no guarantees can be offered to me regarding my treatment or its outcome. Possible risks include awareness under conscious sedation, phlebitis (vein inflammation) at the injection site, aspiration and depressed respiration. I understand that I must not engage in activities that require mental alertness, including driving a motor vehicle, operating machinery or making any financial or business decision for twenty-four hours.

\_\_\_\_\_ I understand these risks of office-based surgery with conscious sedation and would like to have my procedure done in the office. The advantages of doing this include excellent pain control, probable amnesia, decreased cost and convenience. My other options include using only local anesthesia with or without oral pain medication and/or an oral sedative, or having my procedure done in a hospital. I do not want to have my procedure done in the hospital.

**.Driver-Choose One:**

\_\_\_\_\_ I understand that due to the medications I will receive during my visit to Camelback Family planning, I must not drive myself home after my procedure nor engage in any activity requiring mental alertness for twenty-four hours. I have brought a driver with me and he or she will be responsible for ensuring my safe return home.

Driver's Name (Printed): \_\_\_\_\_ Driver's Contact Tel# \_\_\_\_\_

Drivers Signature: \_\_\_\_\_ or

\_\_\_\_\_ I have failed to bring a driver to provide me a ride home. Therefore I am arranging for a taxi to drive me home or I will drive myself home. I have been given the option to reschedule my appointment but am choosing to proceed. I understand that the physician will use her judgment to determine which, if any, medications I may receive. I hereby release Dr. Goodrick of any and all liability and responsibility for my safe return home after receiving any medications.

**Procedure:**

\_\_\_\_\_ I understand that an abortion consists of opening the cervix (the entrance of the uterus) with surgical instruments and/or other dilators and using suction and/or surgical instruments to remove the contents of the uterus. This is one of the most common and safest surgical procedures done in the United States. The actual procedure takes 5-10 minutes.

\_\_\_\_\_ I understand the procedure and I will make sure all of my questions are answered completely to my satisfaction

\_\_\_\_\_ I understand that complications with surgical abortion are uncommon but could include the following:

- \* 1 per 100: Laceration (tearing) of the cervix which may require medication or suturing.
- \* 1 per 1000: Perforation or injury to the uterus which may include damage to internal organs. Hospitalization would be required and surgery may be necessary.
- \* 1 per 1000: Hemorrhage, heavy bleeding that may require evaluation of the patient and further treatment. A blood transfusion might also be needed very rarely.
- \* Reaction to the anesthesia and/or medications resulting in shock, convulsions or death.

\_\_\_\_\_ I acknowledge that the complications that may occur after the procedure are the following:

- \* 1 per 100: Post Abortion Syndrome, trapped blood clots in the uterus that may cause severe cramping and abdominal pain. A second procedure may be required.
- \* Less than 1 per 500: Continuing pregnancy that may be due to multiple pregnancies, double uteri or ectopic pregnancy. A second procedure would be required and an ectopic pregnancy may require hospitalization and treatment.
- \* 1 per 1000: Infection of the uterus with or without infection of the fallopian tubes and ovaries, which may require antibiotic therapy and very rarely can lead to the loss of childbearing capacity.
- \* Hemorrhage, heavy bleeding that may require evaluation of the patient and further treatment.
- \* Emotional problems. Although most women report relief, some women may experience depression or guilt following an abortion. Our staff is available to help women deal with these feelings or provide appropriate referral.

\_\_\_\_\_ In the event of an emergency, I authorize Gabrielle Goodrick M.D. to provide emergency care using her medical judgment, including transfer to a local hospital. I understand that patient confidentiality cannot be preserved if transfer to a hospital is necessary. In the event of an emergency I authorize Gabrielle Goodrick M.D. and staff to contact the following individual:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State \_\_\_\_\_

Telephone number \_\_\_\_\_ Alternate number \_\_\_\_\_

\_\_\_\_\_ I understand that I would be financially responsible for any expenses arising from complications from the abortion procedure. I understand that such complications can be caused by my own condition or conduct and through no fault of the physician. I understand that no guarantees about my future fertility can be offered to me and no such guarantees have been made to me. I will receive written discharge instructions and I understand the importance of follow-up care. I agree to call Camelback Family Planning regarding any question or complications I may have. I understand Camelback Family Planning has the right to refuse me services for whatever reason they deem appropriate.

**Second Trimester over 12 weeks only**

\_\_\_\_\_ If the doctor decides the procedure can be safely completed in one day I will receive Misoprostol a medication that softens and dilates the cervix and a medication to relax me that is similar to Valium. I will then wait at the office for at least 90 minutes before the procedure is done. The visit will be approximately 4-6 hours.

\_\_\_\_\_ If I am over 14 weeks pregnancy, Dr. Goodrick might recommend I have a 2 day procedure. On the first day after IV sedation, laminaria or osmotic dilators (small sticks made of sterile dried seaweed) will be inserted into the cervix. These will expand over night slowly dilating the opening of the uterus. The next day a combination of a suction curette and specially designed forceps are used to remove the products of the pregnancy.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Patient's Name (printed)**

\_\_\_\_\_  
**Medical Provider's Signature**

\_\_\_\_\_  
**Staff Signature**  
Verbally reviewed risks and complications of  
Abortion Procedure

\_\_\_\_\_  
**Date**