

☐ St. Petersburg Woman's
Health Center, Inc.
3401 - 66th Street North
St. Petersburg, Florida 33710
Phone: (727) 381-6620

☐ Tampa Woman's
Health Center, Inc.
2010 E. Fletcher Ave.
Tampa, Florida 33612
Phone: (813) 977-6176

☐ Bread and Roses
Woman's Health Center
1560 S. Highland Avenue
Clearwater, Florida 33756
Phone: (727) 446-2690
Emergency: (727) 562-6796

MEMBERS: NATIONAL ABORTION FEDERATION

PSYCHOLOGICAL INFORMED CONSENT

Each member of our staff is committed to making your visit here as comfortable as possible. We realize that the decision to have an abortion is easier for some women than for others. Your reason for wanting an abortion may be based on a number of circumstances: age, income, future plans, moral and ethical beliefs, relationship with the father, or health. Whatever your personal reason is, it is not unusual to feel alone, angry, insecure, or stupid. Your answers to the following questions will help our staff understand your individual situation and special needs. All information is confidential.

Have you talked with anyone about your decision to have an abortion? ☐ Yes ☐ No

If yes, who? ☐ Doctor ☐ Counselor ☐ Family ☐ Partner ☐ Other: _____

Your decision is based on ☐ Personal Choice ☐ Medical Necessity ☐ Problem With Fetus

Is anyone with you today? ☐ Yes ☐ No If yes, who? _____

Do you feel pressured to have an abortion? ☐ Yes ☐ No If yes, please explain? _____

What doubts or fears do you have about having an abortion? _____

Please initial after you have read and fully understand the possible psychological complications that can result from an abortion.

_____ I have been informed and I understand that the medical procedure I am requesting and consenting to undergo, including termination of pregnancy, may cause me some emotional and/or psychological problems. This includes the possibility that I will reexperience an emotional and/or psychological problem or condition that has troubled me in the past.

_____ I have informed the doctor or medical attendant at the Center of any existing or previously treated emotional or psychological conditions of which I am aware, and I consent to this medical procedure, completely understanding these risks.

Patient _____ Witness _____ Date _____ / _____ /20 _____