

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

CONSENT TO TREATMENT, ANESTHETIC AND OTHER MEDICAL SERVICES

I, _____, age _____, have made the decision to end my pregnancy by abortion under • general anesthesia/ • IV (in the vein.) I authorize Dr. _____ and her/his chosen assistants to perform this procedure and give my permission for the doctor to use professional judgement if an unforeseen condition should arise during the abortion. I understand that it may be necessary for me to have additional procedures that have not been discussed including, but not limited to, anesthesia and surgical procedures.

Please initial on the line to the left of each statement after you have read and fully understand the information.

____ I fully understand that the purpose of this abortion is to end this pregnancy. I know that I can continue this pregnancy to term, but it is my personal choice to end it now. No one has forced me to make this decision.

____ The physician and/or a member of the Center staff has taken the time to explain to me the risks related to having an abortion. Some of these are uterine perforation (a puncture in the uterus.), injury to the cervix, hemorrhage, reaction to general anesthesia, infection and retained tissue.

____ I understand that pelvic examination results are not always exact, and the date of my last menstrual period is important to my treatment. My last normal menstrual period began on _____ / _____
Month / Day

____ I have given the Center my complete past and present medical history, including allergies, blood conditions, medications or drugs taken, hospitalizations and reactions I have had to pain killers and other drugs.

____ I agree to having general anesthetic, pain killers and medications given to me as advised by the doctor or medical attendants except for the following drugs/medications to which I am allergic:

____ I understand that there is a risk of having a negative reaction to the general anesthesia or other medications used during the abortion.

____ I consent to blood samples, cultures, sonogram and procedures that my medical attendants find necessary or advisable while I am being treated for pregnancy termination or any resulting complications. These procedures will not necessarily be related to presently known conditions, and I understand that I will be responsible for the cost of these procedures, and any unpaid balance due will be sent into collections with a 40% collection fee.

____ I understand that due to the sedation method used, I can not drive. I am aware of the possible transient mental impairment

CONSENT TO TREATMENT, ANESTHETIC AND OTHER MEDICAL SERVICES

(Continued from front)

Please initial on the line to the left of each statement after you have read and fully understand the information.

- I understand that if a major complication arises I may have to be hospitalized and may require minor or major surgery to protect my health. I consent to any such emergency treatment and accept responsibility for all fees resulting from additional medical treatment.
- I authorize the Center or physician to dispose of any tissue and parts removed during the abortion in accord with standard medical practice and state law.
- I agree to return to the Center two (2) to four (4) weeks after the abortion for a follow-up examination so that my recovery progress can be checked. I acknowledge that the doctor has in no way guaranteed the results of this abortion.
- I have been encouraged by my doctor, nurse and/or patient advocate to ask any questions I may have, and I will ask any questions I have before leaving the Center. After leaving the Center, I agree to call the Center with any questions or concerns immediately, before calling another doctor or medical facility.
- I understand that a medical problem may be found when my laboratory tests are completed and I
• do • do NOT wish to be contacted at home.

I have read (or have had read to me) and fully understand the "CONSENT TO TREATMENT, ANESTHETIC AND OTHER MEDICAL SERVICES" and I fully understand the information given to me about the procedure.

Patient _____ Witness _____ Date ____ / ____ /20____

Parent/Legal Guardian _____

CONTACT INFORMATION

My home phone number: (____) ____ - ____

My work phone number: (____) ____ - ____

You may leave a message for me with _____
at (____) ____ - ____

Or you may write to me at: _____

City _____ State _____ Zip Code _____

If this is not your permanent address, what is the name of the person who lives there.

