

**Whole Woman's Health of Austin**

8401 North IH 35, Suite 200  
Austin, Texas 78753  
(800) 282-1005 \* (512) 250-1005

**CONSENT FOR TWO DAY D/E PROCEDURE**

**Please initial each section as you read.**

\_\_\_\_\_, I, \_\_\_\_\_, have read, understood, and signed the "INFORMED CONSENT FOR ABORTION, ANESTHETIC AND OTHER MEDICAL SERVICES" consent form, and read the "SECOND TRIMESTER ABORTION SERVICES INFORMATION" packet that includes the "AFTERCARE INSTRUCTIONS: POST LAMINARIA INSERTION" and the "POST OPERATIVE INSTRUCTIONS" forms.

\_\_\_\_\_ I understand that the risks associated with second trimester abortion are potentially greater than a first trimester abortion and include but are not limited to: a) perforation of the uterine wall and nearby organs, b) laceration (tear) of the cervix, c) uterine infection (the risk of infection is higher in women who have gonorrhea, chlamydia, and other types of uterine infection at the time of their abortion procedure), d) retained tissue, retained blood clots or continued pregnancy, e) blood loss requiring medication(s) and/or blood transfusion, f) reaction to medication(s), g) D.I.C. (a rare condition in which the blood fails to clot and may be fatal), h) amniotic fluid embolism in which amniotic fluid from the uterus enters the blood stream causing a serious, and sometimes fatal, bleeding disorder, or the embolism itself may be fatal, i) hysterectomy (removal of the uterus resulting in permanent loss of childbearing capabilities), j) possibility of developing cervical incompetence (difficulty carrying future pregnancies to term), k) Asherman's Syndrome (the formation of scar tissue on the inner wall of the uterus).

LAMINARIA

\_\_\_\_\_ I consent to the insertion of laminaria into my vagina and cervix for the purpose of dilating my cervix, by a licensed physician associated with Whole Woman's Health, Dr. \_\_\_\_\_, and any of Whole Woman's Health agents or employees. I understand that it is the intention of Whole Woman's Health to either remove the fetus in multiple fragments or take surgical steps to cause fetal death before removing the pregnancy.

\_\_\_\_\_ Although the risks are slight, I realize the use of laminaria may cause or contribute to one or more of the following conditions: a)infection, b)spontaneous abortion, c)laceration of the cervix, d) perforation of the cervix and/or uterus, e)septic abortion (infection of the uterus following the abortion), f)heavy bleeding. Further, with the laminaria in place, I may experience side effects such as cramping, bleeding, and/or watery discharge.

\_\_\_\_\_ I understand that I am leaving Whole Woman's Health with laminaria inserted in my cervix and have been instructed that it is absolutely necessary that I return to the clinic at the scheduled time for the second stage of the procedure. I understand that failure to return may result in serious and/or life-threatening medical complications. If the laminaria remains in place longer than the appropriate time period, there is a major risk of infection. If I fail to keep my appointment at Whole Woman's Health for the completion of that abortion, I will be responsible for any medical costs or physical damages I incur as a result of my actions and I release Whole Woman's Health and the physician from all medical and financial responsibility for my healthcare. By not keeping my appointment, I have violated the patient/physician

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contract and the physician may assume that I no longer want or require her/his services. I understand that the fee paid is not refunded.

\_\_\_\_\_ If I experience heavy cramping, moderate to heavy bleeding, loss of laminaria “sticks,” ruptured amniotic fluid, or fainting, I agree to call Whole Woman's Health immediately and follow the physician and/or nurse's instructions.

\_\_\_\_\_ I understand should I fail to return to Whole Woman's Health for the second stage of the abortion procedure, I fully understand that Whole Woman's Health will use every reasonable means available to contact me. This may include but is not limited to, calling my spouse, my parents, my friends, my school, my job or local police as a medical emergency. In their attempt to contact me under these circumstances, I give Whole Woman's Health permission to tell a third person that I am having an abortion since I would be placing myself in serious, even life-threatening risk by failing to return to the clinic.

\_\_\_\_\_ I understand that I am required to stay within 1 hour of the clinic after my laminaria insertion, until the abortion has been completed and I am released by Whole Woman's Health.

\_\_\_\_\_ I understand that when the laminaria is removed and sufficient dilation has not been achieved, the physician may need to insert additional laminaria and I will need to return for the completion of surgery.

\_\_\_\_\_ I understand that to assist in my recovery from surgery, I must follow the “Aftercare Instructions: Post-Laminaria Insertion” and the “Post-Operative Instructions” and I agree to do so.

**CYTOTEC**

\_\_\_\_\_ I understand that Cytotec is given to dilate and soften the cervix. I also understand that it has not yet been approved by the FDA for this use. Using Cytotec in this manner is considered an “off-label” use. The use of Cytotec for cervical preparation is a widely used and accepted medical practice.

\_\_\_\_\_ I understand that if my cervix needs additional preparation in addition to the laminaria, Cytotec will be given.

\_\_\_\_\_ I have been advised and understand the possible side effects of Cytotec, which include, but are not limited to:

- Birth defects
- Uterine cramping and/or contractions
- Vaginal bleeding
- Nausea/Vomiting
- Diarrhea
- Fever and chills
- In very rare cases, tearing of the cervix or rupture of the uterus may occur, which may require additional surgery and/or hospitalization to repair and/or remove the uterus.

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\_\_\_\_\_ I state that I do **NOT** have any of the following conditions, which are contraindications to Cytotec: Allergy to prostoglandins; Inflammatory bowel disease, such as Colitis, Crohns disease or A medical condition that requires me to take "blood thinners" i.e. Aspirin, Coumadin (Warfarin) or Heparin.

**BY MY SIGNATURE AND INITIALS, I VERIFY THAT I HAVE READ (OR HAD READ TO ME), UNDERSTAND THE ABOVE CONSENT, AND GIVE PERMISSION FOR THE INSERTION OF LAMINARIA, THE USE OF CYTOTEC, AND THAT A SECOND TRIMESTER ABORTION BE PERFORMED UPON ME.**

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient name (printed)

\_\_\_\_\_  
Staff signature