

**Whole Woman's Health of Baltimore**

7648 Bel Air Road

Baltimore, Maryland 21236

(800) 997-7942 \* (410) 661-2900

**CONSENT FOR ONE 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", and read the "SECOND TRIMESTER ABORTION SERVICES INFORMATION" packet that includes the "POST OPERATIVE INSTRUCTIONS."

\_\_\_\_ 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).

\_\_\_\_ I consent to manual dilation, and/or insertion of laminaria into my cervix, and/or use of Cytotec 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.

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

**CYTOTEC**

\_\_\_\_ I understand that the use of Cytotec begins the abortion procedure that I have knowingly consented to and requested from Whole Woman's Health, its physicians and staff. If I change my mind and decide not to continue with the abortion once the Cytotec is given, I understand that this decision is against medical advice and I may not be able to continue with the pregnancy and it is likely that birth defects will develop. I have been advised and understand the possible side effects of Cytotec, which include, but are not limited to:

- Birth defects- no assurances have been made to me about the outcome of the pregnancy if I change my mind about having the surgery completed
- 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.

May 2007

Adapted from Northland Family Planning Centers

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\_\_\_\_\_ 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 realize that it is essential that I remain in the clinic for the completion of the abortion once the Cytotec is administered. If I fail for any reason to remain in the clinic for the completion of the abortion, I hereby release Whole Woman's Health, all physicians associated with Whole Woman's Health, their medical staff, agents and employees, from any and all liabilities and legal responsibilities arising from or related to such failure.

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

LAMINARIA

\_\_\_\_\_ I understand that if sufficient dilation has not been achieved, the physician may need to insert or re-insert laminaria, or give more Cytotec to continue dilating the cervical opening. If this occurs I will follow the instructions to either remain in the clinic or return the following day for the completion of the abortion.

\_\_\_\_\_ I am fully aware that in cases when laminaria is used, the laminaria insertion is the first stage of the actual abortion procedure. If I change my mind and decide to have the laminaria removed, I understand that this decision is against medical advice and I may not be able to continue the pregnancy due to the risk of ruptured membranes, infection, and an increased chance of miscarriage due to a dilated cervix.

\_\_\_\_\_ I have been told that laminaria may cause some bleeding, cramping, and/or a watery discharge. Although the risks are small, I understand that cramping, cervical injury, bleeding, fainting, spontaneous abortion, and/or septic abortion are possible.

\_\_\_\_\_ I realize that it is essential that I remain in the clinic for completion of the abortion if laminaria has been inserted. I have been told that any of the complications associated with laminaria are potentially fatal if undiagnosed and untreated. If I fail for any reason to remain in the clinic for completion of abortion, I hereby release Whole Woman's Health, all physicians associated with Whole Woman's Health, their medical staff, agents, and employees, from any and all liabilities and legal responsibilities arising from or related to such failure.

**BY MY SIGNATURE AND INITIALS, I VERIFY THAT I HAVE READ (OR HAD READ TO ME), UNDERSTAND THE ABOVE CONSENT, AND GIVE PERMISSION FOR MANUAL DILATION, 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

\_\_\_\_\_  
Date