Statement of Informed Consent
Medical Abortion

Name:
Date of Birth:
Address:

PLEASE READ CAREFULLY BEFORE SIGNING:

I have been fully informed of, and understand to my complete satisfaction:

- ☐ the medications involved in a medical abortion, how they work to complete an abortion, and how they should be taken;
- ☐ side effects associated with a medical abortion;
- ☐ potential risks and complications associated with a medical abortion, some of which may require further treatment;
- ☐ if my abortion fails and I have an ongoing pregnancy that goes beyond 12 weeks of pregnancy, it is illegal for a doctor to provide an abortion unless there is a risk to life or health, risk to life or health in an emergency or condition likely to lead to death of foetus;
- ☐ if my blood type is rhesus negative and I am over 7 weeks pregnant, an injection of anti-D is part of my abortion care;
- ☐ it is necessary to confirm that the abortion was successful in ending the pregnancy by taking a specific low sensitivity pregnancy test provided to me by my doctor, approximately two weeks after my abortion is complete;
- ☐ pregnancy remains will be disposed of by cremation. If you wish to discuss an alternative please let the doctor know and other choices will be discussed with you.

Patient Statement

The booklet 'Your Guide to Medical Abortion' was provided to me. I have read and understood all information that has been presented to me in this booklet and by my doctor. I have had the opportunity to ask questions about this information. I consent to a medical abortion of my own freewill.

Patient Name: **Signature:** **Date:**	**Parent/Guardian Name:** **(if required)** **Signature:** **Date:**

Medical Practitioner Statement

I confirm that, in my opinion, the patient understands the nature of the treatment. I have provided them with the 'Your Guide to Medical Abortion' booklet and explained what the treatment will involve, the benefits and risks of this and any alternative treatments.
I discussed any particular concerns of this patient. These were explained to my patient in terms suited to their understanding and they are able to give informed consent.

Medical Practitioner Name:
Medical Council Registration Number:
Signature:
Date:

Patient Consent Form for Termination of Pregnancy.

I understand I am taking medicine to end my pregnancy.

I understand that by law my pregnancy must be under 12 weeks gestation (counted from the first day of my last period).

I understand my Doctor will give me two medications.

One I take in the presence of my Doctor and the second I will take 24-48 hours later.

I understand it is my decision when and where I take the second medication within the time frame specified. It is suggested that I plan the process so that it fits with my daily schedule and so that I can have support available should I need it.

My Doctor has explained to me the risks and benefits of the two medications and I understand that once I take the first medication it is not possible to reverse it.

I understand that there is a small possibility that the termination may be unsuccessful (about 2-5 per 100 women who use this treatment) and if this were to occur it is recommended that I have surgical procedure to complete the pregnancy. It is not understood what the harmful effects on a foetus are if the pregnancy were continued as there have been very few cases. However, I understand that the effects while rare may include significant birth defects and be long-term.

I understand that if the termination is not complete my Doctor will refer me to a hospital-based service where I am likely to undergo a surgical procedure to complete the termination.

My Doctor has given me advice on what to do if I develop heavy bleeding, bad pain or need emergency care due to the treatment. I have been given the 24-hour telephone helpline number and I know I am to ring it if I have any concerns.

I know that if possible, I should tell a supportive person that I am taking medication to end a pregnancy and that they know to ring the telephone line of they need to assist me.

I understand that bleeding and cramping do not always mean that my pregnancy has ended.

I understand that I must schedule a follow-up consultation with my Doctor to confirm that the pregnancy has ended and that I have no complications. This visit should be about two weeks after taking the first tablet.

I understand that I must follow my Doctor's instructions on how to take the medication and that I must make sure I have access to emergency medical care in case of need.

If I have the following symptoms, I will contact my Doctor, or if outside office hours the 24-hour telephone advice service.
-If I have a fever <38C that lasts more than 4 hours in the days after taking the medication.
-If I have severe abdominal pain.
-If I soak two or more superabsorbent sanitary pads per hour for two consecutive hours.
-If I am feeling sick including weakness, nausea, vomiting or diarrhoea for more than 24 hours after taking the second medication.

I have read the patient information leaflet and been given an information sheet of 'Frequently asked Questions'.

I have discussed the information with my doctor, and she/he has answered all my questions.

I have made the decision to terminate my pregnancy after consultation with my Doctor.

I have made this decision without coercion and of my own free will.

X_____

Dr_____

Date_____