Patient Name: ____ **Date of Birth:** _________________

NCDHHS MEDICAL ABORTION CONSENT FORM
AND ACKNOWLEDGEMENT OF RISKS STATEMENT

By initialing each of the items below, I certify that I have received the following information about my care:

__________ The physician that will provide the abortion-inducing medication(s) is _____________________.
INITIALS NAME OF PHYSICIAN

If the specific physician is not known, or changes after the time of this consent, the name will be noted below. S/he will be physically present while the first abortion-inducing drug is administered.

S/he ☐ does or ☐ *does* not have local hospital admitting privileges at
____, which offers obstetrical or
HOSPITAL NAME

gynecological care and is located at ____
HOSPITAL ADDRESS

which is within 30 miles from the facility where the abortion is being performed. S/he has liability insurance to cover malpractice in the performance of an abortion unless otherwise
__________ communicated.
INITIALS

☐ *Check if not applicable.*

If applicable, I have been given the name and contact information of the physician or physician
__________ team that will take care of me in the case of any complications after the procedure.
INITIALS

☐ *Check if not applicable.*

__________ The provider ☐ does or ☐ does not accept my insurance.
INITIALS

(Optional) If no hospital is located within 30 miles, the following may be the closest hospital:

____.

S/he ☐ does or ☐ does not have admitting privileges.

By signing here ___________________________________ and initialing each of the items below, I certify that I have been orally informed, in-person, by a qualified health professional, of the following specific information, at least 72 hours before the first abortion-inducing medication was given.

__________ I understand that the probable gestational age of my pregnancy at this time is _____weeks.
INITIALS

I understand that medication(s) will be used that will end my pregnancy and cause the uterus to contract to expel the pregnancy tissue. After receiving these medicines, I might
__________ experience cramping, pelvic pain or bleeding, and the passing of clots and tissue within
INITIALS hours or days. Medications may be given for the pain, cramping and nausea.

I understand the specific medical risks and potential complications of medical abortion. I understand that the risks of complications of medical abortions increase with advancing gestational age. (See Below)

____
INITIALS

I understand the specific medical risks and potential complications of carrying the pregnancy to term (See Below).

____
INITIALS

Risks*	**Medical Abortion**	**Term Pregnancy Delivery**
Infection	Less than 1 in 100	4 in 100
Hemorrhage (Excess Bleeding)	Less than 1 in 100	4-5 in 100
Incomplete abortion/Retained pregnancy tissue	5 in 100	3 out of 100 (retained placenta)
Continuation of the pregnancy	Less than 1 in 100	Does not apply
Risks to future pregnancies: Infertility	Not increased when there are no complications	Not increased when there are no complications
Death (both medical or surgical abortion)**	Less than 0.5 in 100,000 abortions	17-27 per 100,000 live births

**Estimates based on existing studies. For example, 5 in 100 means that 5 people out of 100 who had medical abortion could experience the specific risk.*

***For abortions after 13 weeks, infection and hemorrhage (bleeding) were the leading causes of death.*

I understand that blood type differences (Rh incompatibility) between the pregnant person and the fetus sometimes occur and could cause risks to future pregnancies. Medication is available to prevent this (Rh Immunoglobulin) and some individuals can receive an injection of Rh immunoglobin at the time of the medical abortion to prevent potential future incompatibilities.

____
INITIALS

I understand that I may see the remains of my pregnancy during the process of completing the medical abortion outside the clinic.

____
INITIALS

I may view the fetus(es) by real-time ultrasound and listen to fetal heart tones if present prior to the procedure. I understand that printed information is available to me about locations to receive a pregnancy ultrasound free of charge.

____
INITIALS

____________ I have been given an opportunity to ask questions about my pregnancy, how the embryo and fetus develop, and alternatives to medical abortion.

INITIALS

____________ I understand options other than abortion include carrying the pregnancy to term and either keeping the infant(s) myself or placing the infant(s) for adoption.

INITIALS

____________ I understand a medical abortion is intended to end my pregnancy.

INITIALS

____________ I understand health insurance benefits may be available to me for prenatal care, childbirth, and newborn care.

INITIALS

____________ I understand public assistance benefits may or may not be available to me under Federal and State assistance programs.

INITIALS

____________ I understand if I choose to carry the pregnancy to term, the father of this pregnancy may be legally obligated to assist in support of the child(ren), even if the father has offered to pay for the abortion.

INITIALS

____________ I was told about materials developed by the North Carolina Department of Health and Human Services which describe fetal development and list agencies that offer alternatives to abortion which are available at www.ncdhhs.gov/reprohealth. If I requested printed versions of these materials to review rather than the website, these materials were provided at least 72 hours before the medical abortion.

INITIALS

____________ I was told that the decision to undergo a medical abortion is completely up to me. I was told that I could withdraw my consent for abortion at any time including after the first medication but before the second medication is administered. No matter what I decide, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving State or Federal funds, for which I may otherwise be eligible.

INITIALS

____________ I understand that I have a private right of action to sue the qualified physician performing the abortion if I feel I have been coerced or misled prior to having an abortion. State resources about this right are located at: www.nccourts.gov/help-topics/lawsuits-and-small-claims/lawsuits

INITIALS

____________ I understand that I will be given a copy of all signed forms required by law for this procedure.

INITIALS

__________ I understand that my physician will schedule an appointment 7-14 days after providing the abortion-inducing drug(s) to confirm that the pregnancy is completely terminated and to check for any complications.

INITIALS

__________ I have been given enough information to give informed consent to a medical abortion.

INITIALS

I understand that I will undergo a medical abortion. The discomforts, risks, benefits, and alternatives of the procedure have been explained to me. All my questions have been answered to my satisfaction. I also understand that my anonymous medical data will be released to representatives from the North Carolina Department of Health and Human Services as required by State law, and I understand that I can object in writing to having my medical records reviewed. My foregoing initials and signature and my signature below, confirm that I have voluntarily acknowledged and consented to each specific item listed above.

____ ____

SIGNATURE OF PATIENT/PERSON AUTHORIZED TO CONSENT DATE AND TIME

____ ____

PRINTED NAME OF PATIENT/PERSON AUTHORIZED TO CONSENT RELATIONSHIP TO PATIENT (IF APPLICABLE)

I attest that I have provided this patient with the information presented above in-person.

____

SIGNATURE OF THE QUALIFIED PROFESSIONAL PROVIDING COUNSELING

____ ____

PRINTED NAME DATE AND TIME

Complete if physician is different than previously noted:

I have informed the patient that the physician who will see them is Dr. ___________________________.

S/he does have local hospital admitting privileges at ____.

____

STAFF INITIALS