

Knoxville Center for Reproductive Health (KCRH)
1547 W. Clinch Ave., Knoxville, TN 37916 (865) 637-3861
Surgical Abortion Information and Consent

Initial each line indicating that you understand and consent to the abortion procedure. Please do not sign this consent without reading and understanding its contents. You may discuss any questions or concerns you have with our staff, before signing this consent.

The Knoxville Center for Reproductive Health (KCRH) is a private, nonprofit women's health clinic committed to providing quality reproductive health services. The clinic is fully licensed by the State of Tennessee, and has been in operation since 1975. Our physicians are Board Certified Ob-Gyns with local hospital privileges at UT Medical Center, Parkwest Hospital, Tennova West, Tennova Physicians Regional and Tennova North. In the unlikely event of an emergency while you are in the center, KCRH has an arrangement for emergency medical transport to UT Medical Center. In the unlikely event of an emergency after hours, please call the clinic's local telephone number. The answering service will take your name and number, and a staff member will return your call.

I, _____ consent to a surgical abortion to be performed at Knoxville Center for Reproductive Health.

_____ Before the abortion, I will accurately fill out medical history forms, pay my fee, and be directed through laboratory testing. I consent to blood testing to determine my hemoglobin level (anemia test) and the Rh type of my blood. If my blood Rh type is negative, I will need an additional vaccine injection (Rhogam) at an additional cost.

_____ I consent for the staff of Knoxville Center for Reproductive Health to perform an ultrasound to determine the approximate length of my pregnancy. The ultrasound may be done by putting a probe into my vagina or on my abdomen. I understand the intent of this ultrasound is only to determine the length of the pregnancy, and is not intended to determine any abnormalities of my pregnancy, fetus, or reproductive tract. I understand there are limitations to all imaging techniques, and no technique is 100% accurate or reliable. I release Knoxville Center for Reproductive Health and its employees from any liability arising from this test, particularly in regards to any abnormalities of my pregnancy, fetus, or reproductive tract that have not been evaluated by this ultrasound.

_____ Based on an ultrasound performed by KCRH staff, I am _____ weeks pregnant.

Surgical Abortion Procedure:

_____ If I am fewer than 12 weeks: Before the abortion, I will swallow a prescription strength pain medication (usually 800mg of Ibuprofen) to help with cramping, an antibiotic and medication(s) to help decrease nausea as well as to help me relax. If I have paid for it, I will receive pain medication by injection. This medication is contraindicated with opiod addiction and for patients on opiod antagonists such as, but not limited to, Suboxone. Because these medications can impair my judgment, I understand I must be accompanied by a driver and agree not to drive or operate machinery for eight hours following the medication. I may choose not to take the medication, and can then drive myself home. If I am greater than 10 weeks or my medical history indicates it, I consent to also taking Cytotec to aid in the dilation of my cervix.

_____ If I am further than 12 weeks in the pregnancy, I consent to receive an injection of pain medication for cramping and Phenergan for nausea. This medication is not available to those patients with opiod addictions or on opiod antagonists such as, but not limited to, Suboxone. Because these medications can cause drowsiness and impair my judgment, I understand I must be accompanied by a driver and agree not to drive or operate machinery for eight hours following these medications. I consent to also taking Cytotec to aid in the dilation of my cervix.

_____ A first trimester surgical abortion typically lasts 5–10 minutes (a second trimester abortion usually lasts 10-20 minutes). I understand that in order to give me the best quality care, the procedure may last longer. A female staff will be with me during the procedure to assist me and the doctor. The doctor will do a basic manual pelvic exam and insert an instrument into my vagina to open my vagina, so he/she can see my cervix. He/she will numb my cervix with a local anesthesia (Lidocaine) and apply a tenaculum to hold and to stabilize my cervix. I will likely feel a few “stings” or “pinches” on my cervix. Next, the doctor will insert a series of small metal rods into my vagina and into the opening of my cervix, which will slightly dilate (open) my cervix. I will likely experience some pressure and cramping. Once the cervix has been adequately dilated, the doctor will insert a small hollow tube into my vagina, through the cervical opening, and into my uterus where the pregnancy is located. The vacuum aspirator will be turned on, and I will hear the motorized machine and a suction sound. The doctor may periodically stop suctioning, and use an instrument (a curette) to evaluate the walls of my uterus, and then suction again. The aspiration will empty the contents of my uterus, removing the pregnancy. The aspiration generally lasts 2-3 minutes during a first trimester abortion, and generally 3-15 minutes during a second trimester abortion. During the abortion, I will likely experience moderate to strong menstrual-type cramping.

_____ If any unforeseen conditions arise during the course of the abortion procedure, I further consent to the physician to do whatever is deemed advisable in the exercise of his/her best medical judgment.

_____ **Recovery room:** Following the abortion, I will be observed in the recovery room for approximately 20-60 minutes. I will be offered more pain medication (usually Ibuprofen).

After the Abortion:

_____ **Aftercare:** I may return to most of my normal activities the day after my surgical abortion. It is best to avoid strenuous activity for one week. Becoming too active too soon may increase post-abortion bleeding and cramping, and put me at a higher risk for complications. To help prevent infection, I agree to have nothing in my vagina - including no sex, no tampons, no vaginal creams, etc. for one week. I will receive written after care instructions, and agree to follow all instructions.

_____ I understand I can return to the clinic for a follow-up exam and birth control in three weeks.

_____ **Bleeding:** I understand that after my abortion, I may have some vaginal bleeding for up to three weeks. The amount of bleeding varies greatly from patient to patient. Most women experience some amount of bleeding, off and on, for a week or so. Some women do not bleed at all after an abortion, and some bleed for up to three weeks. Often times, the heaviest bleeding occurs 3 –5 days after the abortion, instead of right at first. Generally, the bleeding does not exceed the flow of the heaviest day of a woman’s menstrual period. I may bleed for a few days, stop bleeding, and then begin bleeding again a few days later. I may pass some blood clots (usually dark in color) from my vagina that range in size from very small to about the size of a half dollar. Bleeding and passing some clots are normal, provided these symptoms are not excessive.

_____ **Cramping:** I understand I may have some cramping off and on for 2 or 3 weeks. If needed, I may take 800 mg of Ibuprofen (Advil or Motrin) at a time, three (3) times a day. Generally, this dosage will relieve the discomfort. I may also receive a prescription for a pain reliever if greater pain control is needed. Many women do not need to fill this prescription. I will be given additional written and verbal instructions regarding how to use these and any other prescribed medications. I agree to follow all directions. I have discussed any medication allergies or other concerns regarding these medications with the clinic staff.

_____ **I agree to call the clinic if: I develop excessive bleeding requiring I change an overnight sized pad more often than once an hour for more than 3 hours; I experience severe cramping or pain the Ibuprofen and prescribed pain medication do not relieve; I repeatedly pass large, bright red blood clots, larger than lemons; or, if I develop a temperature of 100.4 degrees or more. I understand it is my responsibility to contact the clinic should I experience any difficulties following my abortion procedure.**

_____ **Safety and Risks:** Abortion is one of the safest and most commonly performed procedures in the USA. Comparatively, it is actually safer to have an abortion than to carry a pregnancy to full-term. Approximately 97% of women have no complications or post-abortion complaints; approximately 2.5% have a minor problem that can be handled at the clinic; and less than 0.5% require additional surgery and/or hospitalization. I understand that, as with any medical or surgical procedure, there is some risk to body and life. I understand the risks involved in this procedure may include the following:

_____ **Post-abortion Hematometra:** My uterus may fill with blood clots. This condition could cause heavy bleeding, cramping, and repeatedly passing clots. This condition may resolve itself or be treated with medication. It may require I undergo the vacuum aspiration again, in order to remove the blood clots and relieve my symptoms.

_____ **Excessive Bleeding:** Heavy bleeding most commonly can be treated with medication, but may require a second vacuum aspiration procedure. In rare cases it may require hospitalization for a blood transfusion.

_____ **Incomplete Abortion:** If pregnancy tissue remains in the uterus after the abortion, symptoms such as excessive cramping, excessive bleeding, and/or uterine infection can occur. This condition may resolve itself or may require I undergo the vacuum aspiration again, in order to remove the retained tissue.

_____ **Missed Abortion:** In rare cases, the pregnancy can be left intact in the uterus. I would need to undergo the procedure again to have the pregnancy removed. I understand the incidence of a missed abortion increases if I am 6 weeks or earlier in the pregnancy. The doctor may want to order additional lab work or testing if I am very early in my pregnancy. I understand that I can return to the clinic for a follow up exam three weeks after the abortion.

_____ **Laceration of the Cervix:** A tear in the cervix or cervical opening may occur. A tear is usually identified at the time of the procedure. Most cervical lacerations do not require any additional treatment. Occasionally, self-dissolving sutures (stitches) are required to repair the tear.

_____ **Perforation of the Uterus:** If a tear or puncture of the uterus occurs, it is usually identified at the time of the abortion. Typically, the uterus will contract following a perforation, allowing only minimal bleeding. However, if this were to occur before the procedure has been completed, or if there are signs of internal bleeding, admission to the hospital may be necessary to repair the perforation and complete the procedure under general anesthesia.

_____ **Infection:** The risk of infection is minimized by the use of sterile instruments, sterile technique, antibiotics, and most importantly, by me following all aftercare instructions. Signs of an infection include a fever above 100.4 for more than 24 hours, and/or increased cramping, and tenderness in the lower abdomen. An infection may be treated with additional antibiotics, and/or require I have the vacuum aspiration repeated.

_____ **Death:** Any surgical procedure carries a possible risk of death. Death occurs in 0.0006% of all legal surgical abortions (one in 160,000 cases). These rare deaths are usually the result of such things as adverse reactions to medications, embolism, infection or uncontrollable bleeding. In comparison, a woman's risk of death during pregnancy and childbirth is at least ten times greater.

_____ In the event a re-aspiration is required, the Knoxville Center for Reproductive Health will provide the vacuum aspiration at this clinic at no additional charge. However, **I am responsible for any expenses incurred for an emergency room visit or for care at another facility.**

_____ In the event additional lab work is necessary to determine the best course of treatment, I am responsible for any additional charges. The staff is responsible for informing me of any additional costs prior to incurring them if the services are provided by Knoxville Center for Reproductive Health.

_____ **Emotional/Psychological Responses:** The majority of women who elect to have an abortion feel a sense of relief after the abortion. According to the American Psychological Association, research shows that emotional distress appears greatest before, rather than after, an abortion. I understand that a small percentage of women may experience lingering emotional distress after the abortion. Psychological responses to abortion must also be considered in comparison to the psychological impacts of the alternatives – carrying an unwanted pregnancy to term and parenting or making adoption arrangements.

Patient Rights:

_____ Each patient has at least the following rights:

- a) To privacy in treatment and personal care;
- b) To be free from mental and physical abuse. Should this right be violated, the facility must notify the appropriate branch of the Tennessee Department of Human Services immediately;
- c) To refuse treatment. The patient must be informed of the consequences of that decision; the refusal and its reason must be reported to the physician and documented in the medical record;
- d) To refuse experimental treatment and drugs. The patient’s written consent for participation in research must be obtained and retained in his or her medical record;
- e) To have their records kept confidential and private. Written consent by the patient must be obtained prior to the release of information except to persons authorized by law. If the patient is mentally incompetent, written consent is required from the patient’s legal representative. The Knoxville Center for Reproductive Health must have policies to govern access and duplication of the patient’s record;
- f) To have appropriate assessment and management of pain; and
- g) To be involved in the decision making of all aspects of their care.

_____ I understand the purpose of an abortion is to end my pregnancy. I understand the alternatives to having an abortion are: 1) to continue the pregnancy and parent, or 2) to continue the pregnancy and make arrangements for adoption. I have considered these options and am choosing to have an abortion. I understand I cannot be forced and have not been forced by anyone to have an abortion. The abortion is my decision.

_____ I read and understand all information contained in this consent. I hereby request and consent to have an abortion procedure performed on myself.

Patient Signature

Date

For staff use only:	
I have asked this individual questions, and based on the answers she has given me she appears to understand the information being provided.	
_____ Staff Signature	_____ Date
	04/2016