**[HOSPITAL or HEALTHCARE CENTRE]**

# 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;

t 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 tissues will be disposed of as per hospital policy (appropriate for medical abortions within the hospital setting).

## 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:**