Patient N	ame:	Date of Birth:
NCDHHS CONSENT FORM FOR ABORTION IN THE CASE OF A LIFE-LIMITING ANOMALY*  This procedure is being performed due to a physical or genetic disorder identified in the fetus that would be life-limiting. By initialing each of the items below, my physician and I certify that we have discussed the following things prior to the procedure.		
INITIALS	MD INITIALS	How and why my physician determined that the(se) disorder(s) would be life-limiting.
INITIALS	MD INITIALS	The risks that the fetus could die before birth and the fact that some infants with life-limiting disorders are born alive and could have an unknown length of life.
INITIALS	MD INITIALS	Information about and risks associated with the life-limiting disorder(s), including anything that is known about the chance and length of survival from current medical evidence.
INITIALS	MD INITIALS	I have discussed the alternatives to abortion including continuing the pregnancy and having medical care for the infant(s) at birth. I was offered referrals for consultation with experts in newborn intensive care and newborn palliative care (comfort care) to discuss options for stabilization, evaluation, possible treatments, including the possibility of home discharge for comfort care for the infant(s) should I decide to continue the pregnancy.
		☐ Check if not applicable.  If the abortion is a medical abortion or a surgical abortion, all the information on the applicable NCDHHS Abortion Consent Form has been provided.
	_	applicable NCDHHS Abortion Consent Form has been provided.  and signature below confirm that I have voluntarily acknowledged and secific item listed above.

DATE AND TIME

RELATIONSHIP TO PATIENT (IF APPLICABLE)

SIGNATURE OF PATIENT/PERSON AUTHORIZED TO CONSENT

PRINTED NAME OF PATIENT/PERSON AUTHORIZED TO CONSENT

<sup>\*</sup>Per North Carolina Session Law 2023-14, an abortion during the first 24 weeks of a woman's pregnancy is lawful if a qualified physician determines there exists a life-limiting anomaly.