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

NCDHHS SURGICAL 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:

__________ INITIALS

The physician that will perform the procedure is ________________________________.
NAME OF PHYSICIAN

If the specific physician is not known at the time of this consent or changes after the consent, the name will be noted below. S/he will be physically present during the entire procedure.

S/he ☐ does or ☐ does not have local hospital admitting privileges at

____ located at
HOSPITAL NAME

____
HOSPITAL ADDRESS

__________ INITIALS

which is within 30 miles from the facility where the abortion is being performed. S/he does have malpractice insurance to cover this procedure unless otherwise communicated.

☐ *Check if not applicable.*

__________ INITIALS

If applicable, I have been given the name and phone number of the physician or physician team who will take care of me in the event of complications associated with the procedure.

☐ *Check if not applicable.*

__________ INITIALS

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

(Optional) If no hospital 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 surgical abortion procedure.

__________ INITIALS

I understand that the probable gestational age of my pregnancy at this time is ____ weeks.

__________ INITIALS

I understand the specific medical risks and potential complications of the surgical abortion. (See table at the top of the next page.)

___________ I understand the specific medical risks and potential complications of carrying the pregnancy to term. (See table at the top of the next page.)

INITIALS

Risks*	Surgical Abortion	Term Pregnancy Delivery
Infection	2-3 in 1000	4 in 100
Hemorrhage (bleeding)	1-3 in 1000	4-5 in 100
Uterine Injury: ▪ Perforation - poking a hole in the uterus ▪ Rupture – bursting open of the uterus	Perforation: Less than 1 in 100	Rupture: Less than 1 in 100
Cervical Tear	In first trimester: Less than 1 in 1000 In second trimester: 2-3 in 100	Less than 1 in 100
Risks to future pregnancies: Preterm birth	Unclear evidence about increased risk of preterm birth after surgical abortion	10-11 in 100 pregnancies
Psychological effects (Mood disorders) (both medical and surgical abortion)	Anxiety: 10-16 in 100 over 3 years Depression: 9-14 in 100 over 3 years	Anxiety: 14 in 100 over 3 years Depression: 10 in 100 over 3 years
Death (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, 2 in 1000 means that 2 people out of 1000 who had the procedure could experience that specific risk.*

___________ I may view the fetus(es) by ultrasound and/or 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 other options to surgical abortion.

INITIALS

___________ I understand alternatives to 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 surgical 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 have been 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 available at www.ncdhhs.gov/reprohealth. If I have requested printed versions of these materials to review rather than the website, these materials were provided at least 72 hours before the procedure.

INITIALS

____________ I was told that the decision to undergo a surgical abortion is completely up to me. I was told that I could withdraw my consent for an abortion at any time prior to or during the procedure. 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 have been given enough information to give informed consent to a surgical abortion.

INITIALS

I understand that I will undergo a surgical 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