CONSENT FOR ABORTION

I hereby direct and request the physician from **Reproductive Health Services to perform a suction aspiration abortion**. If any unforeseen circumstances arise, or are discovered during the course of the abortion, which call for additional procedures in addition to, or different from those contemplated, I further request and authorize the physician to take whatever measures he/she deems medically necessary.

I understand that the purpose of the procedure is to terminate my pregnancy, but that no guarantee has been made to me regarding the outcome of this surgery. It has been explained to me that, in rare instances, the pregnancy is not terminated and, if that happens, further treatment may be necessary at my expense. I understand the procedure is done by suction aspiration of the uterus.

I further understand that the **risks involved include, but are not limited to, perforation of the uterus with possible damage to abdominal organs; hemorrhage; blood clots in the uterus; cervical tear; infection; low blood pressure immediately following the procedure; allergic reaction to the local anesthesia; hysterectomy; sterility; failure to terminate the pregnancy and emotional reaction.** If I experience any complications that require emergency medical care, I understand that I am financially responsible for the cost of said care. I agree to seek additional care promptly, if advised to do so.

I have been told that, as an alternative to abortion, I may choose to continue this pregnancy and either parent the child or elect adoption.

I agree to read the aftercare instruction sheet and contact Reproductive Health Services if I experience any of the symptoms listed on said sheet. I further consent to the disposal of any tissue removed from my body during the abortion. I have been told that it is my responsibility to return for a follow up visit with a sample of my first morning urine. I understand that if I fail to bring this specimen, Reporoductive Health Services cannot adequately assure me that I am no longer pregnant.

I hereby release the physician and staff from any and all claims arising out of, or connected with, the above procedure or any resulting complications and expenses. My signature below authorizes release of any medical records pertaining to health care services associated with this abortion. I understand that I am pre-signing a medical release form for Reproductive Health Services to obtain copies of any subsequent medical records related to this abortion.

I certify that I have read and fully understand this consent. I further state that consent is given without coercion or duress.

Signature_____ Date_____

Witness_____ Time_____

Germantown Reproductive Health Services, 13233 Executive Park Terr., Germantown, MD