ABORTION APPOINTMENT FORM

Pt Name: Appt Date/Time: MAB or SAB

❑ Face to Face ❑ Telephone Day, Date, Time appointment Scheduled _____

Phone (____)_____ DOB _____ AGE* _____ NEED INTERPRETER? Y N
Ok to say PP is calling? Yes or No LANGUAGE_____

MEDICAL INFORMATION

LNMP _____ Probable gest. age at time of appt. ____wks ____days. Patient informed (staff initial_____)

Positive Pregnancy Test: ❑ Yes ❑ No If no, do not schedule
US/Pelvic Confirmation? ❑ Yes ❑ No If yes, when? _____ # weeks _____ By whom? _____
History of seizures? ❑ Yes ❑ No If yes, take seizure medication the day of the appointment. Pt. must have a ride home.
History of hypertension? ❑ Yes ❑ No if yes, take hypertension medication the day of the appointment.
History of diabetes? ❑ Yes ❑ No If yes, bring insulin kit.
History of asthma? ❑ Yes ❑ No If yes, must bring inhaler.
Chronic steroid use? ❑ Yes ❑ No
Heart condition for which normally takes antibiotics? ❑ Yes ❑ No If yes, pt must speak with nurse.
RH Negative ❑ Yes ❑ No, if so there will be an additional charge, we will test for this.
Are you taking any other medications? ❑ Yes ❑ No If yes, take medication as usual, including on the day of the appointment.

Are you interested in a Medication or Surgical Abortion: ❑ SAB ❑MAB
Refer to procedure descriptions if needed

INFORMED CONSENT TELEPHONE SCRIPT

(PATIENT'S NAME), my name is _____ and I am a staff person at Planned Parenthood of Minnesota, North Dakota, South Dakota's Sioux Falls Clinic. South Dakota Law requires that I provide you with the following information at least 24 hours before your abortion.

❑ I am required to inform you that Medicaid benefits may be available to you for prenatal care, childbirth, and neonatal care.

❑ I am required to inform you that the father is responsible to assist in the support of the child, even if he has offered to pay for the abortion.

❑ I am also required to tell you that you have the right to review a booklet on fetal development and a website related to pregnancy prepared by the State of South Dakota at no charge to you. If you request, we will provide you with a copy of the printed materials and the website address. If you choose to review the booklet, you may either come into the clinic at least 24 hours before your appointment to pick it up, or I can mail it by certified, restricted delivery mail to you. If I mail it, I must allow at least 72 hours before your scheduled appointment.
Do you choose to receive the information on the booklet? ❒ Yes ❒ No If yes, ❒ Mail ❒ Pick-up
Website address: www.state.sd.us/doh/ given? ❒ Yes ❒ No

South Dakota Law also requires that the doctor who will be performing your abortion inform you of the risks associated with a first trimester abortion and with the risks associated with carrying your pregnancy to term, at least 24 hours prior to performing the abortion. You have two options: come in and discuss the risks with the doctor in person, or I can play a tape, recorded by the doctor, for you over the phone. Which would you prefer? Visit / Tape The tape will only take 3 to 4 minutes, and I need you to stay on the line when it has finished so that I may give you further information. The name of the physician that will be performing your procedure is _____. I will transfer you to the message now. **(PLAY TAPED MESSAGE)**

I am Dr. _____, staff physician for Planned Parenthood of Minnesota/South Dakota's Sioux Falls Clinic, and I will be performing your abortion. Based on the information you have provided, the probable gestational age of the fetus at the time of your abortion will between 4 & 8 weeks/8 & 12 weeks/12 weeks & 13w6d. However, this calculation is not 100 percent accurate and will be confirmed during your appointment. Risks associated with all first trimester abortions are rare. As there are two methods of abortion, I will give you the risks for both. For a surgical abortion the risks include but are not limited to: infection of the uterus, 1 in 500; incomplete procedure or retained tissue, 4 in 1000; hemorrhage or excessive bleeding, 2 in 1000; and perforation of the uterus, 4 in 1000 procedures. For a medical abortion the risks include but are not limited to: infection of the uterus 2 in 10,000; ongoing pregnancy 3 in a 1000; hemorrhage or excessive bleeding 2 in 1000 procedures. In a small percentage of patients, a surgical abortion will be needed to complete the medical procedure. An uncomplicated first trimester abortion does not affect your ability to have a normal pregnancy in the future and causes no increased risk of infertility or ectopic pregnancy. Should you decide to carry your pregnancy to term, the most common risks are hemorrhage, infection, toxemia, kidney failure, gestational diabetes and prolapse of the bladder. The most common cause of death in term pregnancy is blood clots especially those traveling to the lungs. The overall risk of death from term pregnancy is ten times higher than death from a first trimester abortion, but is still very rare in the United States.
At the time of your abortion, you will be required to sign a statement documenting that I provided this information to you over the telephone at least 24 hours before you abortion. Any questions you have will be answered fully at the time you are seen in our clinic.

What was the number of the recording that you heard? _____

FINANCIAL INFORMATION

Do you use state Medical Assistance or have health insurance? ❑ YES ❑ NO

If NO: Cash fees are based on income. What is your total annual household income? _____
How many people including yourself does this support? _____ Based on the information you have provided, the price of the procedure will be _____.
We accept cash, money orders, visa, mastercard and discover. We do not accept personal checks or American express and you will need to pay for the entire procedure the day of your appointment.

IF YES: ❑ Insurance/Medical Assistance/MN Care: If MA, what state? MN SD IA NE
Name & address of Policy Holder (PH) _____
Relation to Pt. _____ PH's Employer _____ PH's DOB _____
Insurance Co. Name _____ Cust. Svc. # _____
ID# _____ Group # _____
Covered for procedure? ❑ Yes ❑ No Copay? ❑ Yes ❑ No Amt: $_____ Effect. Date_____
Bring card the day of your appointment! We will call and preauthorize your abortion services. At what # can we call you if your insurance will not cover abortions? _____ Password _____
If patient not covered, follow up call made and cash fee infor. given. _____

INSTRUCTIONS

- ❑ The day of your procedure, you need to bring a photo ID with DOB & address.
- ❑ You should have a ride home if possible, although it is not mandatory, therefore you are allowed to bring one adult guest with you, however, your adult guest will also need a photo ID.
- ❑ You will be at the clinic a good majority of the day.
- ❑ Feel free to eat before you come, and you may have the opportunity to step out at some point to eat.
- ❑ We prefer no children in the clinic, and you are welcome to have your cell phone with you, but we prefer that it is turned off.
- ❑ Also, no aspirin, ibuprofen, alcohol of any type or illegal drugs 24 hours before appt, however, Tylenol is OK.

Do you have any questions regarding the information we just covered?

We have you scheduled for (date)_____at (time)_____**Please call if you need to reschedule or cancel.** Don't forget your photo ID and insurance card!

CHECK ALL APPLICABLE: ❒ Pre-Appointment Forms
❒ State Fetal Development Booklet

Patient's Mailing Address City State Zip Code

Pre-Appointment Forms Mailed: ❑ Patient Registration ❑ HIPAA Privacy Notice ❑ Medical History
❑ Procedure Specific Brochure
Mailed By: _____ Date Mailed: _____

Fetal Development Booklet - Certified/Restricted Mail By: _____ Date _____(Attach Certified Registered Mail Receipts)
If patient picks up Booklet: Patient's Signature _____ Date _____ Time _____AM/PM

***PARENTAL NOTIFICATION COMPLIANCE** ❑ NOT APPLICABLE (Patient 18 or older)

If patient is less than 18, check the appropriate box:

❑ Emancipated ❑ Bringing Notarized Form ❑ Parents Coming ❑ Court Bypass
❑ Mailed Form #_____

Parent/Guardian Name: _____ Mailing Address: _____

Staff Signature _____ Date _____ Time _____ AM/PM