

SD I understand that some of the above mentioned complications can be successfully treated at the time of the abortion. For those occurring after a patient leaves the clinic, the most important factor is to seek medical attention immediately. Long term problems are extremely rare if follow up care is received promptly.

SD I understand that (check one):

☒ A local anesthesia will be injected in the area of my cervix.

☐ A general anesthesia will be administered by means of injecting fluid into my vein; this will cause me to "be asleep" during the procedure, during which time I may be given oxygen by face mask. I have been given the opportunity to have the risks of sleep anesthesia explained in detail. I understand that I may ask any question of the person administering the anesthesia. I will inform the person administering the anesthesia of any medications or recreational drugs I am currently taking. I understand I must not drive myself home from the clinic.

SD I have received a full explanation of the abortion and have seen an audio-visual presentation and have no further questions. I have also received a full explanation of the proper care I should take of myself after I leave the clinic.

SD I hereby authorize the doctor and his/her assistants or designees to provide such additional services for me as may be necessary, including but not limited to, the administration and maintenance of anesthesia, blood transfusions and/or the performance of services of pathology and radiology. In the event that an emergency situation occurs, I authorized the doctor to perform such surgical and medical procedures as (s)he deems necessary for my well being.

SD I authorize the pathologist to use his/her discretion in the disposal of any tissue.

SD I understand that my physician needs to have complete and honest information about my medical history in order to provide the safest abortion procedure possible. I have reported the correct date of my last normal menstrual period as accurately as I can. I realize that drugs (both legal and street drugs) I may be taking, or past medical problems may affect the safety of abortion. I have reported any serious medical problems I have had in the past including: Allergy or a bad reaction to medication, severe anemia, bleeding or clotting disorder, asthma, heart problems including mitral valve prolapse, epilepsy, high blood pressure or previous infection involving the uterus or tubes (pelvic inflammatory disease).

SD I understand that the Clinic (1) is required by law to release upon demand information which may be contained in the patient's medical records to authorized agencies of the government and (2) is required to release information, if applicable, to insurance companies, MediCal, or other persons or entities responsible for the payment of late charges and I consent to this.

SD In the event that it is deemed necessary by the doctor to transfer me to the hospital, I hereby agree that all contents of this consent shall also apply to emergency care given to me at said hospital and the Pregnancy Consultation Center does not assume responsibility for the hospital and expenses.

SD I give my permission to be contacted in the future by the staff of this clinic for the purpose of follow up pertaining to my health and well being. Such contact will be made with the utmost discretion.

Patient Signature Sapna Dav

Date 5/8/03 2:15

Witness Signature Ajay & Der
L. Moretto

Date 5/8/03
5/8/03 2:15