Clinic for Women
3607 West 16th Street Suite B-2
Indianapolis, IN 46222
317-955-2641

PHOTO ID	Medicaid Card School ID

Receipt

Chart #____________________________ Date _________________________

Pt. Name _______________________________ Age __________ DOB ________________

Address ____

City ______________ ST _________ ZIP ________ County of Residence _______________

Home Phone ( ) _________________________ Work Phone ( ) ___________________

Place of Employment____

Work Address _____________________________ City _______ ST _______ ZIP _________

In *Case of Emergency*, Contact ____________________________ Relationship __________

Address _________________________________ City _________ ST _______ ZIP _______

Home Phone ( ) ____________________________ Work ( ) ______________________

Does your emergency contact know about the reason for your visit? Yes _______ No ______

Clinic for Women
3607 West 16th Street Suite B-2
Indianapolis, IN 46222
317-955-2641

Prelab Payment Consent Form

I, ______________________________, understand that I am paying $150 for Prelab Services. The fees cover services during the first visit. This payment is non-refundable. If I decide not to return for the scheduled procedure appointment, *I understand that I must call to reschedule* for a new appointment. *If I do not reschedule and return for my surgical or medical procedure within two weeks, I understand that I will forfeit the $150 which I am paying for services rendered today.*

____ ___________________________
Patient's Signature Date

____ ___________________________
Parent or Guardian Signature, if patient is a minor Date

CLINIC FOR WOMEN NOTICE OF PRIVACY PRACTICES

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to provide a copy of our privacy practices.

This notice describes how we protect your health information and what rights you have to that information.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health operations. Examples of how we use or disclose information for treatment purposes are: scheduling appointments, prescribing medication, faxing medical records to a referring physician for services, or getting information from a prior health care provider.

Examples of how we use or disclose your health care information are: asking you about your health care plan, other sources of payment, preparing and sending insurance claims, and collecting unpaid balances.

Examples of how we use or disclose information for health care operations are: financial or billing audits, internal quality assurance, personnel decisions, managed care plans, defense of legal matters, business planning and outside storage of our records. This includes all operations administrative and managerial that must be performed to run our office.

We routinely use your health information inside our office for these purposes without any special permission. If we must share your health information outside of our office for these reasons we will inform you and ask for special permission.

By signing and dating below I acknowledge that I have been provided with a copy of this practice.

____ ___________________________
Patient's Signature Date

____ ___________________________
Parent or Guardian Signature, if patient is a minor Date

CLINIC FOR WOMEN – MEDICAL HISTORY

Chart # ____________________ Date __________________ Age _________ DOB _________________

Pt. Name ____ Marital Status: S M D W

Education (enter highest grade completed):____

Home Phone (____) ______________________________ Work Phone (_____) _____________________

Allergies to Medications? N Y If yes, list ____

Medications Currently Taking ____

Do you smoke? N Y How much? ____pk/day How many years? ____________ I quit, date _______

Do you drink alcohol? N Y How many drinks per week? ______

Have you ever used IV drugs, cocaine or marijuana? N Y If yes, which drugs? _________

Have you ever experienced physical, sexual or emotional abuse? N Y If yes, who knows about this?______

Have you ever had surgery? N Y NA What kind? ______________ When? ___________________

Name of your gynecologist or private physician____

GYNECOLOGICAL HISTORY

First day of last period? ___________________

Was it: normal short spotty long heavy

Are your periods usually: heavy moderate light

Are your cramps: none mild moderate severe

How often do your periods occur? _____ days

What birth control were you using when you got pregnant?_____________

What birth control do you want today? ______________

Date of last physical exam________ Date of last pap test___________

How many pregnancies before this one? ___

# of vag births ____ # of c-sections ______

# of abortions _____ # of ectopic preg ____

# of miscarriages __ Your blood type_____

List any problems with pregnancies_______

Have you used this birth control before? Y N

Was it normal? Yes No NA

Have you ever had any of the following? (Circle the correct response.)

Abnormal pap smear	N	Y
PID or Pelvic Inflammatory Disease	N	Y
Blood transfusion	N	Y
Heart Murmur/Mitral Valve Prolapse	N	Y
Problems with contraception	N	Y
Gonorrhea or Chlamydia	N	Y
Venereal Warts or Herpes	N	Y
Blood clots in legs, lungs	N	Y
Serious illness	N	Y
Major surgery	N	Y

Please explain all "yes" answers, including when it occurred ____

Have you or any of your family had any of the following? (Check only if it applies)

	Self	Mother	Father
Heart disease/attack	☐	☐	☐
High blood pressure	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Blood clots	☐	☐	☐
Varicose veins	☐	☐	☐
Fainting spells	☐	☐	☐
Epilepsy/Convulsions/Seizures	☐	☐	☐
Migraine headaches	☐	☐	☐
Stroke/Numbness	☐	☐	☐
Diabetes/Sugar	☐	☐	☐
Thyroid disease	☐	☐	☐
Adrenal disease	☐	☐	☐
Anemia	☐	☐	☐
Sickle Cell Anemia or Trait	☐	☐	☐
Glaucoma	☐	☐	☐
Other___	☐	☐	☐

	Self	Mother	Father
Psychiatric treatment	☐	☐	☐
Drug/Alcohol Addiction treatment	☐	☐	☐
Hepatitis/Liver Disease/Mono	☐	☐	☐
Kidney problems	☐	☐	☐
Bladder problems	☐	☐	☐
Breast disease	☐	☐	☐
Asthma	☐	☐	☐
Respiratory problems	☐	☐	☐
TB or lung problems	☐	☐	☐
Cancer: Genital	☐	☐	☐
Breast	☐	☐	☐
Other_______	☐	☐	☐
Fibroids/Cysts	☐	☐	☐
Ovary/Fallopian Tube problems	☐	☐	☐
Infection of Ovary/Tube/Uterus	☐	☐	☐
Abnormal Vaginal Discharge	☐	☐	☐

I understand that misrepresenting my medical history and current medical status could result in surgical and/or medical complications. By my signature I declare the above information to be truthful.

Patient Signature ____ Date _________________________

Allergies	CLINIC FOR WOMEN SURGERY REPORT ***FOR CLINIC USE ONLY***	Rh factor

Patient Name ___________________________________ Date of service___________ Chart# ___________

S/O Here today:__________________ SMOKER/NON-SMOKER Age _____________

SONO RESULTS______WKS_____DAYS TECH INITIALS____________SONO DATE___________

Patient's estimated Date of Fertilization (2wks less than sono date)______________________________

2nd SONO RESULTS _______WKS_____DAYS **TECH INITIALS** ___________ **SONO DATE** ___________

Contraception Choice: __________________________

Preoperative Report:

Ht _________ Wt. _______lbs. Hct.______ Rh- **Negative/Positive**

B/P _______ Pulse _______ Temp ________ Leuk _______ Nit _______ Prot ________ Glu _______

☐ Valium: 5mg / 10mg #1 po ☐ Motrin 800mg #1 po ☐ Naproxen Na 275mg #2 po Time given:________am/pm

☐ Cytotec 200mcg #2 buccal Time given: ____________ am/pm Staff Signature _________________

Physician Record:

Examination: The attending physician has reviewed the patient's current medical history.

Uterine position: ☐ Antiverted ☐ Retroverted/Flexed ☐ Mid

Gestational size ________ wks by Bimanual/Sono Adnexa: ☐ Normal ☐ Abnormal

Procedure:

Anesthesia: ☐ Lidocaine 1% with Sodium Bicarbonate 8.4% Total ml _______

Application: ☐ Paracervical ☐ Intracervical ☐ Other ___________________________

☐ Dilation and Suction ☐ Curettage ☐ Sharp Curette ________ ☐ Other __________

Cannula/Curette size _______mm Time completed _______________ am/pm

Physician's Orders: Patient is in stable condition after receiving local anesthetic during the surgical abortion Procedure and is discharged to and from the post anesthetic care unit.

Physician's Post-Operative Medications Dispensed/Ordered

☐ Methergine 0.2mg #1 po upon recovery ☐ Disp. Methergine 0.2mg #4 po q 12h

☐ Disp. Amoxicillin 500mg #2 po q 24h ☐ Disp. Cipro 500mg #2 po q 24h

☐ Contraception_____________________ ☐ MICRhogam IM

☐ Vicodin 5mg/500mg #5 po q 4-6h **Physician's Initials** ____________, M.D _______/_______/______

RH HCT HCG UA____

____

Physician Signature: _________________________**M.D.**

Tissue: Sac: **Y N** Chorionic Villi: **Y N** Fetal Parts: **Y N** Ectopic Watch: **Y N**

Specimen to **CYTO/PATH: Y N**

Specimen Tech Signature: _____________________ **Physician's Initials:** ___________________

PATIENT CONSENT FORM FOR TERMINATION OF PREGNANCY
DO NOT SIGN UNLESS YOU FULLY UNDERSTAND THE FOLLOWING

1. I, ________________________________ am ____ years old. I request that an abortion, which is a surgical procedure to end my pregnancy, be performed on me by _________________________, a contract physician with Clinic for Women (CFW).
   Physician's Name

***INSTRUCTIONS TO PATIENT:** Please put your initials in each parenthesis as you read, understand, and agree:*

(   ) 2. I have made this decision to have an abortion because I do not want to have a baby at this time. I know my other choices are giving birth and adoption, but abortion is my personal choice. No one is forcing me to choose abortion, it is my decision.

(   ) 3. I have told all of my past and present medical history, including allergies, blood conditions, prior medicines and drugs taken, also any adverse reactions to anesthesia, medicines, or drugs. I understand that a full and complete disclosure of my medical history is important to help minimize the risks of complications which may occur with an abortion. I understand that the physician of CFW is relying on my information to be truthful and complete.

(   ) 4. The first day of my last normal period was _______________, 20____. I have described in today's medical history any unusual characteristics of this period because I realize this information is important in determining how far into my pregnancy I am and whether an abortion can be done in an out patient clinic in Indiana. The physician's decision to proceed with the abortion is based on the above information as well as findings from examination and possible ultrasound.

(   ) 5. I give my consent to be given local anesthesia or pain medicine except _________________, because I am allergic to it. I understand that local anesthesia does not eliminate all pain, and that in a small number of cases, patients could have a severe allergic reaction to a local anesthetic including shock, or even death.

(   ) 6. I give my consent to the taking of cultures, smears and other medical tests that the physician feels is appropriate or necessary. I understand that tissue and/or fetal parts will be removed during the abortion and I give my permission for them to be disposed of according to state law.

(   ) 7. I understand that there are risks of both major and minor complications which may occur with this, as with all surgical procedures. No guarantee has been made to me. These complications can include, but are not limited to, perforation of the uterus (putting a hole through the uterine muscle) or damage to the cervix, uterus or adjacent organs, hemorrhage (severe bleeding), retained tissue and/or infection, all of which could be severe enough to require surgery resulting in hysterectomy (removal of the uterus), and/or sterility (never being able to become pregnant again), or even death. If any of the above reactions or complications do occur, I further realize that I may need to be hospitalized which would be at my own expense. I realize that such complications can be caused by other medical conditions not related to the pregnancy termination procedure and/or by my failure to follow postoperative instructions, or by the treatment of the follow-up physician.

(   ) 8. Should I require hospitalization or medical treatment by a physician not affiliated with CFW for any reason related to this abortion, I now give my permission for the release of all medical records associated with such care. I understand that I am giving my permission prior to such care.

(   ) 9. If an unforeseen condition or complication arises during the abortion which in accordance with good medical practice calls for a different or additional treatment, I give the physician permission to do whatever in her/his professional judgment is necessary. Examples of such treatment are: the administration of IV fluids, the use of ultrasound during the abortion, repair/suturing of a cervical tear.

(   ) 10. I fully understand that there is no guarantee that this abortion will terminate my pregnancy. Which could result in continuing pregnancy or incomplete abortion requiring an additional procedure or other very rare complications including death. Therefore, it is very important that I have a post-abortion check-up within 4 weeks to be certain that I am no longer pregnant and that no other medical problem has occurred of which I may be unaware.

(   ) 11. I have had full opportunity to ask questions about my abortion and the risks and alternatives involved and am satisfied with the answers. I understand that any further questions I may have will be answered before I leave the clinic -1 have only to ask them. I understand that it is my responsibility to bring to the attention of CFW any post-abortion problems I may encounter. The problems could include fever, heavy bleeding, severe cramping or pain, unusual or foul smelling discharge, or the absence of a normal period within six weeks of the procedure. I realize that, should any such problems arise, immediate treatment may be necessary to avoid more severe complications. I also realize that any questions I have after leaving the clinic today can be answered by calling CFW, since our telephone is answered 24 hours a day, seven days a week.

( ) 12. I understand that following an abortion I may experience feelings of regret and/or depression - emotional distress. I have been told that resolution of my feelings prior to the abortion procedure is the best protection from emotional distress post-operatively. I have had an opportunity to fully discuss my feelings about this pregnancy and impending abortion and am comfortable with my decision to terminate this pregnancy. I wish to schedule additional time for discussion of emotions/feelings associated with this abortion before proceeding:
(Please circle one) Yes No

( ) 13. I am a minor who has gone through the Judicial Bypass procedure. I understand that it may still be necessary to contact my parent or legal guardian to get consent from that person in the event of an emergency or a complication that requires hospitalization.

( ) 14. Any birth control methods I wished to know more about have been explained to me and I plan to use _________ _________________. If I have chosen birth control pills, I understand that their possible side effects include severe headaches, leg cramps, blurred vision, blood clots, chest pains and stroke. I agree to report any and all side effects to CFW or to my own health care practitioner.

( ) 15. I understand that serious problems after an abortion are rare and could be resolved right in the clinic without further cost to me. I also understand that if I do not contact CFW, but instead go to an emergency room or another doctor for care, CFW cannot be responsible for any costs or treatment that results.

I certify that I have read (or have had read to me) and fully understand the above consent form regarding my abortion, that the explanations therein referred to were made and that I completed all blanks or statements.

DO NOT SIGN UNTIL YOU HAVE COMPLETELY READ AND FULLY UNDERSTAND THE ABOVE.

PATIENT'S SIGNATURE ____ DATE _______________________

PARENT SIGNATURE, if patient is a minor ______________________________ DATE _______________________

STAFF SIGNATURE ____ DATE _______________________

==

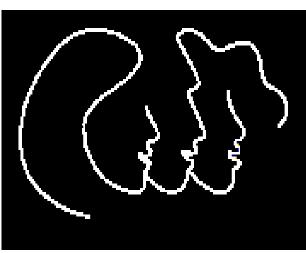
I give permission for release of my records from Clinic for Women to:

Name (Doctor or Clinic) ____

Address____

____ _________________________________

PATIENT SIGNATURE DATE



For Clinic Use Only

Patient Education

Previous Pt/Group Education ________am/pm

Patient has received patient education about the procedure, recovery, and aftercare instructions: Staff Signature________

Procedure, Recovery, and Aftercare questions/concerns:

____

____

____

1. Contraception Choice: OCP/ Nuva Ring/ Ortho Evra/ Depo Provera
   Other: __________________; risks/side effects of hormonal contraception discussed? Y/N

2. Discussed other options of birth control? Y/N. If yes, what __________________________

3. Birth control from own physician: Y/N

4. Post op appointment in four weeks on ______________@ ________am/pm
   Other: ____

5. AB consent form signed: Y/N

Does patient feel conflicted or unsure about decision based on the responses regarding the answers to some of the questions recorded on "How are you feeling" form? Y/N
If yes, Outsource Referral list given? Y/N

Staff Signature _____________________ **Date _____________________**

Individual Education ________ am/pm

Emotional Health Questionnaire

HOW ARE YOU FEELING? Name ____________________________ Date ________________________

1. If you have considered options other than abortion, what are they?_______________________

2. Was this a difficult___ or an easy ___ decision?

3. Whose decision is it for you to have this abortion? _______________________________

4. Have you discussed your decision with anyone? _______________ If so, who?_____________________

5. Name of the father involved in this pregnancy? ______________________________ His age: ____________

6. Does he know of your decision? Y/N

7. Does he support your decision? Y/N

8. Please circle all the words that describe how you feel:

sad	guilty	numb	selfish
angry	confused	resolved	unsure
confident	scared	trapped	conflicted
relieved	nervous	others: ___________________________	

9. Please check off the items below that concern you the most today.

___ Someone is forcing or pushing me to do this.
___ How I will feel emotionally after the abortion.
___ Whether abortions are safe.
___ If I will be able to have children later.
___ I wish someone else would make the decision.
___ How abortions are done.
___ If the abortion will hurt.
___ Fetal development

Staff Notes: ____

____

____

Physician Consult: ____

____

____

Staff Signature: ____ **Date:** ________________________________