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Date of service______________________

PATIENT DEMOGRAPHICS

PHOTO
ID

MEDICAID CARD
STUDENT ID
MILIARTY ID

Receipt

Chart # ______________________________ Date ______________________________

Pt. Name ______________________________ Age ________ DOB ____________________

Highest Ed *(circle)* *8th or less / 9-11th / HS/GED / Some College / Associate's / Bachelor's / Master's / Doctorate*

Marital Status *(circle)* *Married / Never Married / Divorced / Widowed / Lives With Partner*

Race(s)
(✓ all that apply)
___ *Black/African American* ___ *White/Caucasian* ___ *Latina/Hispanic* ___ *Other*
___ *Asian* ___ *American Indian/Alaskan Native* ___ *Hawaiian/Pacific Islander*

Address ______________________________

City ______________________________

ST, Zip ______________________________

County NOT Country ______________________________

Phone ( ) ______________________________

Emergency Contact ______________________________

Address ______________________________

City ______________________________

ST, Zip ______________________________

Cnt. Phone ( ) ______________________________

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

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Payment Consent Form

I, _____________________________, understand that I am paying $200 for Prelab Services. This fee covers services provided during the first visit and the $200 is non-refundable. During this first visit, I understand that I will be scheduling the dates and times for my abortion procedure and follow-up appointment. The abortion procedure **must be completed within 14 days** of my first visit.

RESCHEUDLING FEES: ***These fees cover the costs of re-doing your lab-work, ultrasound, or administration fees.***

- There is a **$100** rescheduling fee if you reschedule your procedure appointment. It must be rescheduled **within 14 days** of your initial prelab appointment.
- There is a **$200** rescheduling fee if your rescheduled procedure appointment is **more than 14 days** from your initial prelab appointment.
- There is a **$50** rescheduling fee if you reschedule your post-op appointment. This must be completed during the NEXT available post-op date (the next week).

NOTE: NO funding or outside resources can be used to cover any rescheduling fees.

______________________________ ______________
Patient 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 our privacy practices.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Parent or Guardian Signature (if patient is a minor) Date

ALLERGY STICKER	3607 W 16th St, Ste B2 Indianapolis, IN 46222-2556 P: (317) 955-2641 / F: (317) 955-2687 clinic4women.net / info@clinic4women.net	RH STICKER

SONOGRAM REPORT

Patient Name: ____ Chart # ____________

Age _____ Est. Fertilization Date: ___________ LMP: ____________ Date of Service: ___________

			Patient Int.
I would like a copy of the ISDH Abortion Informed Consent Brochure.	Yes _____	No _____	__________
I would like to purchase a copy of my sonogram picture for $5.00.	Yes _____	No _____	__________
I understand the ultrasound is for gestational dating and to assure the pregnancy is in the uterus.			__________
I have received information on Available AB Counseling & Abuse/Coercion/Harassment/Trafficking			__________

Check appropriate Box

Technique	Abdominal		Vaginal		Mean Sac Diameter	Measurement	Gestational Age (weeks)
Planes Scanned	Longitudinal		Transverse		1 2	cm cm	
Single Gestation	Yes		Multiple		3 Average	cm cm	
Intrauterine	Yes		No		Crown-Rump Length	cm	
Yolk sac	Yes		No		Biparietal Diameter	cm	
Cardiac activity	Yes		No		Femur Length	cm	

Patient purchased _______ sono picture(s) PLACE PRE-LAB SONO PICTURE HERE Gestationsl sac L+H+W (divided by) 3+30=Gestational age	PLACE POST SONO PICTURE HERE

Prelab urine pregnancy test results: ___ Positive ___ Negative

Neg Sono/ Rtn Date and Time: _______/_______/_______, _______ am / pm

Performing Sonographer Signature: ________________________________ Date: ______________

Physician Review: __________ Adequate __________ Inadequate __________ Referral

Physician’s Signature: ______________________________ Date: _______________

ABORTION FETAL ULTRASOUND AND HEART TONE CERTIFICATION

State Form 55321 (R3 / 6-18)
INDIANA STATE DEPARTMENT OF HEALTH – IC 16-34-2-1.1(a)(5)

INSTRUCTIONS: Before an abortion is performed, the provider must perform a fetal ultrasound and fetal heart tone procedure. The provider must enable the pregnant woman to view the fetal ultrasound image and hear the heartbeat of the fetus, if the fetal heart tone is audible. The purpose of this form is to document your opportunity to view the image and hear the heart tone. In this form, "abortion" refers to either a surgical abortion or a medication abortion (abortion resulting from an abortion inducing drug). The completed form is kept by the provider as part of your medical record.

I affirm that this form is being completed prior to the abortion.

The abortion provider has offered me the opportunity to view the fetal ultrasound image. I selected the following *(check the appropriate selection)*:

- ☐ I wish to view the fetal ultrasound imaging that will be done prior to the abortion.
- ☐ I decline to view the fetal ultrasound imaging that will be done prior to the abortion.

The abortion provider has offered me the opportunity to hear the auscultation of the fetal heart tone, if the fetal heart tone is audible. I selected the following *(check the appropriate selection)*:

- ☐ I wish to hear the fetal heart tone, if audible prior to the abortion.
- ☐ I decline to hear the fetal heart tone, if audible prior to the abortion.

I hereby certify that information has been provided to me as indicated above.

______________________	______________________	
Printed name of patient	Patient's medical record number	
		am / pm
______________________	______________________	______________
Signature of patient	Date *(month, day, year)*	Time

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RH STICKER

***FOR CLINIC USE ONLY:**

SURGERY REPORT

Patient Name ______________________ Date of service______________ Chart# ____________

Here today with:______________________ SMOKER / NON-SMOKER Age ________

SONO RESULTS	WKS	DAYS	TECH INIT	SONO DATE
1st Sono result	______	______	______	______
2nd Sono result	______	______	______	______

☐ **Check here if this surgery is a result of a FAILED/INCOMPLETE ABORTION.**

☐ PATIENT HAS BEEN TO THE LAB TODAY FOR **POST-OP** VISIT: ________ (staff INT)

Contraception Choice: None / OCP / Nuva Ring / Ortho Evra / Depo Provera / Other: ______________________

Physician's Order(s): Pre-Operative Medication(s):

				Time given:	Staff Init
☐ Metronidazole 500mg	☐ Amoxicillin... 500mg		☐ Other ______	am / pm	______
☐ Naproxen 500mg	☐ Ibuprofen..... 800mg	☐ Tylenol.... 500mg	☐ Other ______	am / pm	______
☐ Cytotec............400mcg, buccual		☐ Other ______		am / pm	______
☐ Valium 5mg	☐ Valium 10mg	☐ Other ______		am / pm	______

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

Uterine position: ☐ Antiverted ☐ Retroverted/Flexed ☐ Mid

Gestational size: _______ wks Determined via **Bimanual / Sono** Adnexa: **Normal / Abnormal**

INSPECT/Narcotic and pre-anesthesia evaluation review date: ____/____/____ Physician Initials: ______**, M.D.**

SOI Given ____/____/____ ________ am / pm

SOI PLUS 18 hours ____/____/____ ________ am / pm

Procedure: Start time: ____________ **am / pm**

Anesthesia: ☐ Lidocaine 1% Total ml _______ **Application:** ☐ Paracervical ☐ Intracervical

Method: ☐ Dilation and Suction ☐ Curettage ☐ Sharp Curette ________ / Cannula/Curette **size** ________________mm

Procedure: Time Completed: ____________ **am / pm**

Post-Operative Medication(s):

☐ Methergine 0.2mg upon recovery; IM

☐ MICRhoGAM IM

☐ Contraception: ______________________

☐Other: ______________________

Specimen Tech Initials.......... ________

Tissue Sac................................	Y / N
Chorionic Vill	Y / N
Fetal Parts	Y / N
Ectopic Watch	Y / N
Specimen to CYTO/PATH.........	Y / N

Physician's Orders: RH / HCT / UA / HCG

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. I have also reviewed the specimen with Specimen Tech to verify presence of the tissue/parts indicated above.

Physician's Signature: ______________________ **Date**:______________

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Date___________________________

RECOVERY NOTES

Pt. Name____ Chart #_________________________

Allergy Problems____
Current Medications____

Admission to Recovery______________ am / pm

Vitals: B/P ______________ Pulse_____________ ________________ am / pm
______________ _____________ ________________ am / pm
3rd B/P if prior B/P elevated ______________ _____________ ________________ am / pm

General Physical Condition:
Skin: clammy cold dizzy dry hot light-headed nauseous ok pale sweaty warm

Assessment scale
Cramping on admission: (Circle one): None Light Moderate Heavy Vomited: est._____cc _________am/pm

Pre-operative medication(s):
☐ **Valium:** 5mg / 10mg ☐ **Ibuprofen** 800mg ☐ **Naproxen** 500mg ☐ **Tylenol** 500mg ☐ **Cytotec** 200mcg #2 buccal
☐ **Metronidazole** 500mg #1 po ☐ **Amoxicillin** 500mg #1 po

Medication Administered:
☐ Atropine IM: lot#__________ Exp Date___________ Site__________
☐ Methergine Maleate 0.2mg: IM: lot#__________ Exp Date___________ Site__________
☐ Immune Globulin; mini dose IM: lot#_____________________ Exp Date_______________ Site________________
☐ Depo-Provera: Lot # _________________________ Exp Date ______________________ Site __________________
☐ Other ____

Medication Dispensed/Ordered:
☐ Contraception x _____ cycles: Nuva Ring/Ortho Cyclen/Ortho Tri-Cyclen/Other_______________
☐ Other: ________________________

☐ Dispensed written and oral post-operative instructions, including administration, side effects, and contraindication of all medications received and after-hours telephone number
☐ Scant tissue/Ectopic warnings given

☐ Post-Op follow-up: ☐ Will call with pregnancy test results ☐ Post-Op with own doctor ☐ Undecided

Patient Assessment scale:
Vaginal Bleeding: Circle: None, Scant, Light, Moderate, Heavy Pad Count ________
Cramping: Circle: None, Light, Moderate, Heavy
General Condition of Patient:____
Against Medical Advice:____
Emergency Transport Needed: __Yes __No
Patient is stable and ambulatory. She may be discharged from recovery per Physician's order, unless indicated otherwise.
Discharge from Recovery: ___________am/pm

Patients read and sign prior to leaving. (Pacientes: Lea y firme antes de salir)

I have been given a copy of the abortion aftercare instructions and the after-hours contact number (317) 955-2641 to take home. They have been explained to me and I agree to follow them. My failure to follow them releases Clinic for Women from any liability or responsibility for my care.
(Me han dado una copia de las instrucciones para mi cuidado despues de mi cirugia. Las entiendo y si no las sigo, la clinica no tiene la responsibilidad de mi cuidado ni de mi salud.)

___________________________________/________________ ____________________________________
Patient Signature (Firme de paciente) / Date **Recovery Attendant Signature**

____
Parent/Guardian Signature (Si menor de edad, firma de paciente)

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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).

<u>INSTRUCTIONS TO PATIENT:</u> 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 ____________________________**___________.
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.

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( ) 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 problems that after an abortion are rare. If the problem can be resolved in the clinic or by calling the clinic for instruction these services are provided without further cost to me. It is MY responsibility to adhere to all of my follow up appointments and contact the clinic if there are any issues. The clinic reserves the right to refer me to an outside physician if they cannot resolve the problem in the clinic OR if the issue is past a reasonable post-op time frame. I will be responsible for associated costs. 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.

( ) 13 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 or after the procedure:
(Please circle one) Yes No

( ) 14 I understand I have the right to determine the final disposition of my aborted fetus. I have informed Clinic for Women in writing and have completed and submitted the form prescribed by the Indiana State Department of Health of my decision for disposition of my aborted fetus before it may be discharged from the clinic. Also, I understand that it is my responsibility to provide the container for my aborted fetus. I understand Clinic for Women must obtain parental consent if I am a minor, unless I have received a waiver of parental consent under IC 16-34-2-4. I understand Clinic for Women will release my aborted fetus to me as long as I have completed the required forms, provided a container for my aborted fetus, and have paid the processing fee of $300.00. I would like to take my aborted fetus with me.
(Please circle one) Yes No

( ) minor 15 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.

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'S SIGNATURE ______________________________ DATE ____________________

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Patient Name ___________________________ Pt# _____________ Phone _______________

Date	Nurse / Staff : Patient Notes

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PATIENT MEDICAL HISTORY

Pt. Name ______________________ Chart # ______________________
Date ______________ Age __________ DOB ______________________

Medication Allergies: ______________________________
Current Medications: ______________________________
Do you smoke or use nicotine products? .... N / Y → ________ pks/day
* Have used marijuana or illegal substances in the past 48 hours? .... N / Y → Which drugs? .... ______________
* Have you consumed alcohol in the past 48 hours? .... N / Y
***NOTES**:*
Have you ever had vaginal or abdominal surgery in the past 3 months? .. N / Y → When? .... ______________
-What procedure did you have done? .... ______________

GYNECOLOGICAL HISTORY

PREVIOUS **number** or "**0**": Vag Births______ C-sections______ Ectopic preg______ Miscarriages______ Abortions______

List any problems with pregnancies.....______________________________
Name of your gynecologist or phys .....______________________________
First day of last normal menstrual pd...______________________________
Are your periods usually.......... heavy moderate light
Are your cramps usually.......... none mild moderate severe
How often do your periods occur........ every ________ days OR irregular **My periods usually last:** ________ days OR irregular
What birth control were you using when you got pregnant? ______________________________
Date of last physical exam..........______________ **Any Issues?**....... N / Y ______________
Date of last pap test..........______________ **Was it normal?** .. N / Y ______________

Have you ever had any of the following? (Circle the correct response.) Please explain all "yes" answers, including when it occurred

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

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

CONDITION	Self	Mother	Father	CONDITION	Self	Mother	Father
Heart disease/attack	☐	☐	☐	Psychiatric treatment..........	☐	☐	☐
High blood pressure	☐	☐	☐	Drug/Alcohol Addiction treatment.........	☐	☐	☐
Thyroid disease..........	☐	☐	☐	Hepatitis/Liver Disease/Mono	☐	☐	☐
Blood clots..........	☐	☐	☐	Breast disease	☐	☐	☐
Diabetes/Sugar	☐	☐	☐	Asthma	☐	☐	☐
Fainting spells..........	☐	☐	☐	Respiratory problems	☐	☐	☐
Epilepsy/Convulsions/Seizures	☐	☐	☐	TB or lung problems..........	☐	☐	☐
Migraine headaches	☐	☐	☐	Cancer: ______________	☐	☐	☐
Stroke/Numbness	☐	☐	☐	Fibroids/Cysts	☐	☐	☐
Adrenal disease..........	☐	☐	☐	Ovary/Fallopian Tube problems..........	☐	☐	☐
Abnormal Vaginal Discharge	☐	☐	☐	Infection of Ovary/Tube/Uterus..........	☐	☐	☐

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 ______________

Staff Signature ______________________ Date ______________

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EMOTIONAL HEALTH AND PATIENT EDUCATION

Patient Name ______________________________ Date ______________

Patient Emotional Health Questionnaire: Patient please answer questions 1-10.

1. Have you have considered options other than abortion? .... **Y / N**
   - If YES for #1, what other options did you consider? .... ______________________
2. On a scale of 1-10 (1=easy, 10=very difficult) how easy was this decision?.......... 1 2 3 4 5 6 7 8 9 10
3. Whose decision is it for you to have this abortion?...................... Self / Partner's / Other:
4. Have you discussed your decision with anyone? With whom?... **Y / N** ______________________
5. **Name** AND **Age** of father involved in this pregnancy? .... ______________________, AGE______
6. Does father know of your decision? .... **Y / N**
7. Does father support your decision? .... **Y / N / Not Applicable**
8. Please circle all the words that describe how you feel
   confident relieved trapped conflicted unsure sad scared confused
   resolved guilty selfish numb nervous angry
9. Please check off the items below that concern you the most today
   ___Whether abortions are safe ____Fetal development ____If I will be able to have children later
   ___Someone is forcing/pushing me to do this ____How I'll feel emotionally after the abortion
10. Are you seeking an abortion as a result of being **abused**, **coerced** (forced), **harassed**, or **trafficked**? **Y / N**

STOP: Below this line is for ***Clinic Use Only***: ******PATIENT EDUCATION******

Group Education: *Patient has received education about the procedure, recovery, and aftercare instructions:*

***Staff Signature:** ______________________ **Date:** ______________ **Time:**__________ **am/pm**

Individual Education:

1. Procedure, Recovery, and Aftercare patient questions/concerns: ...**NONE / Answered in Group / Questions/Concerns Below:**

____

____

2. CFW Contraception Choice: .... None / OCP / Nuva Ring / Ortho Evra / Depo
3. Other choice (if applicable, ie: physician) .... ______________________
4. Available contraceptives discussed and signed?................................ **Y / N**
5. Discussed other options of birth control?.. **Y / N** condoms / spermicide /
6. AB consent form signed: .... **Y / N**
7. Based on my conversation with this patient she is okay with her decision **Y / N**
8. If NO for #7, Outsource Referral list given? .... **Y / N**

Patient has received education about birth control, conflictions, after-care counseling, and been able to ask any questions:

***Staff Signature:** ______________________ **Date:** ______________ **Time:**__________ **am/pm**

Physician Consult ____

____

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AVAILABLE CONTRACEPTIVES & CONTRACEPTIVE CONSENT FORM

Clinic For Women offers the following birth control options:

1. Birth Control Pill
2. Nuva Ring
3. Ortho Evra "The Patch"
4. Depo Provera

Factors to be considered: Recently published scientific studies have indicated that there probably is an increased risk of developing serious circulatory disease, including heart attack, in certain women with high risk factors who use contraception containing ESTROGEN. Although heavy smoking appears to contribute the greatest risk, each health factor acts to multiply a woman's risk.

The following list contains the current medically recognized risk factors. Those risks that in your case may increase the possibility of developing serious complications while using oral contraceptives.

PERSONAL or FAMILY History of:

- Smoking
- 35 years old and older
- Overweight or obese
- Hypertension
- High Cholesterol
- Diabetes; parents, siblings
- Heart attack under age 50 in one or both parents
- Deep Vein Thrombosis (blood clots in arteries)

However, some women experience these additional benefits from using Oral contraception:

- Predictable periods, lighter bleeding, and/or decreased cramps
- Decreased ovarian cysts, endometrial cancer, and/or ovarian cancer
- Skin improvement; acne

I understand and agree to the following:

a. It is **my** responsibility to make and keep regular appointments with my Health Care Provider as required for continued birth control evaluation or options.
b. It is best to stop using hormonal contraception at the end of the complete cycle or one month. However, if I wish to stop, I may do so at any time during the month. I understand, I may experience sporadic (on and off bleeding), or irregular periods.
c. I am aware of the contraceptives that Clinic For Women has to offer AND have been given DIRECTIONS FOR USE as well as information about the RISKS, WARNING SIGNS & SIDE EFFECTS associated with my choice.
d. If I do not want any of the contraception offered by Clinic For Women, information about other available birth control options will be provided to me if I desire.

I would like additional information on: ____

Patient Signature ______________________________ Date ____________________

Parent Signature (if patient is minor) ______________________________ Date ____________________

Staff Signature ______________________________ Date ____________________