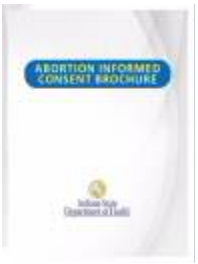
ABORTION INFORMED CONSENT CERTIFICATION

State Form 55320 (R / 8-16)
Indiana State Department of Health – IC 16-34-2-1.1(a)

PURPOSE OF FORM: This form documents your voluntary and informed consent to an abortion at least eighteen (18) hours before the abortion. 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. You will be provided with a copy of the completed form.



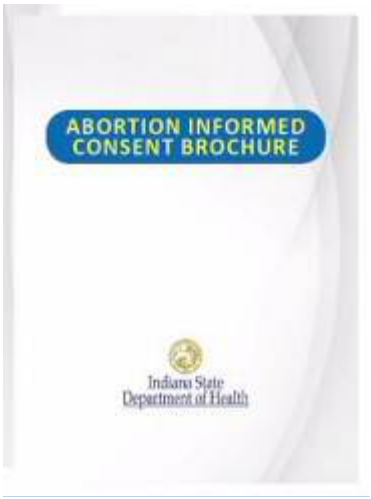
Patient Certification of Informed Consent

I certify and affirm that:

1. The physician who is to perform the abortion, the referring physician or a physician assistant (as defined in IC 25-27.5-2-10), an advanced practice nurse (as defined in IC 25-23-1-1(b)), or a midwife (as defined in IC 34-18-2-19) to whom the responsibility has been delegated by the physician who is to perform the abortion or the referring physician has, in private and not a group, at least eighteen (18) hours before the abortion is performed, informed me orally and in writing of the following:
   A. The name of the physician performing the abortion, the physician's medical license number, and an emergency telephone number where the physician or the physician's designee may be contacted on a twenty-four (24) hour a day, seven (7) day a week basis.
   B. That follow-up care by the physician or the physician's designee (if the designee is licensed under IC 25-22.5) is available on an appropriate and timely basis when clinically necessary.
   C. The nature of the proposed procedure or information concerning the abortion inducing drug.
   D. Objective scientific information of the risks of and alternatives to the procedure or the use of an abortion inducing drug, including:
      (1) the risk of infection and hemorrhage;
      (2) the potential danger to a subsequent pregnancy; and
      (3) the potential danger of infertility.
   E. That human physical life begins when a human ovum is fertilized by a human sperm.
   F. The probable gestational age of the fetus at the time the abortion is to be performed, including:
      (1) a picture of a fetus;
      (2) the dimensions of a fetus; and
      (3) relevant information on the potential survival of an unborn fetus; at this stage of development.
   G. The medical risks associated with carrying the fetus to term.
   H. The availability of fetal ultrasound imaging and auscultation of fetal heart tone services to enable the pregnant woman to view the image and hear the heartbeat of the fetus and how to obtain access to these services.
   I. The pregnancy of a child less than fifteen (15) years of age may constitute child abuse under Indiana law if the act included an adult and must be reported to the department of child services or the local law enforcement agency under IC 31-33-5.

2. I have been informed orally and in writing of the following:
   A. That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care from the county office of the division of family resources.
   B. That the father of the unborn fetus is legally required to assist in the support of the child. In the case of rape, the information required under this clause may be omitted.
   C. That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.
   D. That there are physical risks to the pregnant woman in having an abortion, both during the abortion procedure and after.
   E. That Indiana has enacted the safe haven law under IC 31-34-2.5.

3. I have been provided a color copy of the ISDH Informed Consent Brochure (image to the right is of the brochure) and been informed that the ISDH Informed Consent Brochure is posted on the ISDH Web site. The internet web site address of the Indiana State Department of Health's web site is www.in.gov/isdh. The direct link to the ISDH Terminated Pregnancy (Abortion) Information is www.in.gov/isdh/25199.htm



The ISDH Informed Consent Brochure includes the following information:

A. Objective scientific information concerning the probable anatomical and physiological characteristics of a fetus every two (2) weeks of gestational age, including the following:
   (1) Realistic pictures in color for each age of the fetus, including the dimensions of the fetus.
   (2) Whether there is any possibility of the fetus surviving outside the womb.
B. Objective scientific information concerning the medical risks associated with each abortion procedure and abortion inducing drug, including the following:
   (1) The risks of infection and hemorrhaging.
   (2) The potential danger:
      (i) to a subsequent pregnancy; or
      (ii) of infertility.
C. Information concerning the medical risks associated with carrying the child to term.
D. Information that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care.
E. Information that the biological father is liable for assistance in support of the child, regardless of whether the biological father has offered to pay for an abortion.
F. Information regarding telephone 211 dialing code services for accessing human services as described in IC 8-1-19.5, and the types of services that are available through this service.

4. This form is being completed at least eighteen (18) hours before the abortion.

5. I voluntarily consent to the abortion.

6. I certify the following: *(Select appropriate item.)*

_____ I am eighteen (18) years of age or older. *(Attach documentation of age.)*

_____ I am under eighteen (18) years of age but have been emancipated by a court order or issued a waiver of parental consent by a juvenile court. *(Attach copy of court order or waiver.)*

_____ I am under eighteen (18) years of age *(Parent or guardian consent required; see following section.)*

_____ _____
Printed Name of Patient | Patient's Medical Record Number

_____ _____ _____
Signature of Patient | Date *(month, day, year)* | Time

Parent / Guardian Certification ***(if required)***

The consent of a parent or guardian is required if a woman having the abortion is under the age of eighteen (18) unless the woman has been emancipated by a court order or issued a waiver of parental consent by a juvenile court.

I certify that:

1. I am the parent or legal guardian of the patient identified above. *(Attach documentation of parental or guardian status.)*
2. My child or ward, in private and not a group, has been provided the information and items identified in paragraphs 1-3 above.
3. This form is being completed at least eighteen (18) hours before the abortion.
4. My child or ward voluntarily consents to having the abortion.
5. I voluntarily consent to my child or ward having the abortion.

_____ _____

Printed Name of Parent / Guardian Relationship to Patient

_____ _____ _____

Signature of Parent Guardian Date *(month, day, year)* Time

Provider Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the information and items described above were provided to the patient named above, in private and not a group.
2. The patient has voluntarily consented to the abortion as reflected above.
3. If applicable, the patient's parent or guardian has voluntarily consented to the abortion as reflected above.
4. A completed copy of this form has been provided to the patient and, if applicable, the patient's parent or guardian.

_____ _____ _____

Printed Name of Physician or Other Provider Professional Credentials License Number

_____ _____

Signature of Physician or Other Provider Date *(month, day, year)*

AVAILABLE COUNSELING AFTER AN ABORTION

State Form 56115 (8-16)
Indiana State Department of Health – IC 16-34-2-1.1(a)(2)(J)

PURPOSE OF FORM: This form documents that you are timely provided with information concerning any counseling that is available to you after having an abortion. At least eighteen (18) hours before the abortion, the provider must inform you orally and in writing of any counseling that is available to you after having an abortion. The completed form is kept by the provider as part of your medical record. You will be provided with a copy of the completed form.

Counseling Information

Information concerning counseling that is available to a woman after having an abortion:

Real Alternatives *(unlicensed)*
Telephone: 1-888-LIFE AID
Website: www.realalternatives.org

Indiana 211 Partnership *(referral source)*
Telephone: 2-1-1 *(where supported)*
Website: www.in211.org

International Hotline for Abortion Recovery *(licensed and unlicensed)*
Telephone: 866-482-5433
Website: www.internationalhelpline.org

National Board for Certified Counselors *(counselor directory)*
Telephone: 336-547-0607
Website: www.nbcc.org/CounselorFind

The Indiana Professional Licensing Agency (317-232-2980, www.in.gov/pla) has listings and other information about licensed counselors in Indiana.

Patient Certification

I certify that:

1. I have been informed orally and in writing of the above information.
2. The above information was provided to me and this form is being completed at least eighteen (18) hours prior to the abortion.

I further certify the following: *(Select appropriate item.)*

_____ I am eighteen (18) years of age or older. *(Attach documentation of age.)*

_____ I am under eighteen (18) years of age but have been emancipated by a court order or issued a waiver of parental consent by a juvenile court. *(Attach copy of court order or waiver.)*

_____ I am under eighteen (18) years of age. *(Parent or guardian consent required; see following section.)*

_____ _____
Printed Name of Patient | Patient's Medical Record Number

_____ _____ _____
Signature of Patient | Date *(month, day, year)* | Time

Parent / Guardian Certification ***(if required)***

The consent of a parent or guardian is required if a woman having the abortion is under the age of eighteen (18) unless the woman has been emancipated by a court order or issued a waiver of parental consent by a juvenile court.

I certify that:

1. I am the parent or legal guardian of the patient identified above. *(Attach documentation of parental or guardian status.)*

2. My child or ward has been provided orally and in writing with information concerning any counseling that is available to her after having an abortion.

3. The above information has been provided to my child or ward at least eighteen (18) hours before the abortion.

_____ _____
Printed Name of Parent / Guardian Relationship to Patient

_____ _____ _____
Signature of Parent Guardian Date *(month, day, year)* Time

Provider Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the patient named above has been provided orally and in writing with information concerning any counseling that is available to her after having an abortion.

2. A completed copy of this form has been provided to the patient and, if applicable, to the patient's parent or guardian.

_____ _____ _____
Printed Name of Physician or Other Provider Professional Credentials License Number

_____ _____
Signature of Physician or Other Provider Date *(month, day, year)*

DISPOSITION OF ABORTED FETUS CERTIFICATION

State Form 56114 (8-16)
Indiana State Department of Health – IC 16-34-2-1.1(a)(2) / IC 16-34-3-2(b)

PURPOSE OF FORM: This form documents your decision concerning the disposition of the aborted fetus. The completed form is kept by the provider as part of your medical record. You will be provided with a copy of the completed form.

If you decide for the provider to be responsible for disposition, the provider may dispose of the aborted fetus by incineration as medical waste, burial, or cremation. Ask the provider if you want to know the specific method for disposition of the aborted fetus in this case.

Patient Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the provider has informed me orally and in writing that I have a right to determine the final disposition of the aborted fetus; provided me with information concerning the available options for disposition of the aborted fetus; and, if applicable, told me the specific method for disposition of the aborted fetus in this case.

2. I have decided to dispose of the aborted fetus by:

   _____ Abortion clinic / health care facility will dispose of the aborted fetus

   _____ I am taking responsibility for disposition of the aborted fetus and will incur those costs

I further certify the following: *(Select appropriate item.)*

_____ I am eighteen (18) years of age or older. *(Attach documentation of age.)*

_____ I am under eighteen (18) years of age but have been emancipated by a court order or issued a waiver of parental consent by a juvenile court. *(Attach copy of court order or waiver.)*

_____ I am under eighteen (18) years of age. *(Parent or guardian consent required; see following section.)*

_____ _____
Printed Name of Patient | Patient's Medical Record Number

_____ _____ _____
Signature of Patient | Date *(month, day, year)* | Time

Parent / Guardian Certification ***(if required)***

The consent of a parent or guardian is required if a woman having the abortion is under the age of eighteen (18) unless the woman has been emancipated by a court order or issued a waiver of parental consent by a juvenile court.

I certify that:

1. I am the parent or legal guardian of the patient identified above. *(Attach documentation of parental or guardian status.)*

2. At least eighteen (18) hours before the abortion, my child or ward has been provided the information described above.

3. My child or ward has determined the disposition of the aborted fetus as selected above.

4. I consent in my child or ward's disposition of the aborted fetus as selected above.

_____ _____
Printed Name of Parent / Guardian Relationship to Patient

_____ _____ _____
Signature of Parent / Guardian Date *(month, day, year)* Time

Provider Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the patient named above has been informed orally and in writing that she has a right to determine the final disposition of the aborted fetus; provided with information concerning the available options for disposition of the aborted fetus; and, if applicable, told which specific method of disposition will be used in this case.

2. The patient has determined the disposition of the aborted fetus as selected above.

3. If applicable, the patient's parent or guardian has consented in the patient's determination of disposition of the aborted fetus as selected above.

4. A completed copy of this form has been provided to the patient and, if applicable, to the patient's parent or guardian.

_____ _____ _____
Printed Name of Physician or Other Provider Professional Credentials License Number

_____ _____
Signature of Physician or Other Provider Date *(month, day, year)*