

NAME:
DR. CHANG

DOB:

SS# 000-00-0000

ID#

6/25/2014 2:26:09 PM

¹Patient Registration Form & Consent for Medical Treatment

First Name _____	MI _____	Last Name _____
Birth Date _____	SS# _____	Marital Status _____
Street Address _____	Apt # _____	
City _____	State _____	Zip Code _____
Race _____		
Home Phone _____	Work Phone _____	Ext _____ Cell phone _____
Employer _____	Occupation _____	
Insurance Carrier _____	Plan Type: _____	Policy Holder _____
Relationship _____	Policy # _____	Group # _____
Secondary Insurance Information _____		
Emergency Contact Name & Phone #: _____		

REQUEST FOR MEDICAL TREATMENT

I request that Gynemed Surgical Center provide me with medical treatment. If the clinicians at Gynemed Surgical Center are unable to provide me care for the symptoms that I present, they will provide me with a referral to an appropriate provider.

I have completely and accurately disclosed my medical history including: allergies, current medical treatment, surgical history, and any medications or other drugs previously or current being used.

I consent to all applicable testing that is a necessary part of my care. This includes blood drawing, ultrasounds and collection of specimens for evaluation.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical care.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

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Financial and Insurance Billing Policy

Patient with active health insurance coverage through a carrier with whom this practice contracts must have their benefits verified before each visit. Third-party billing is offered with the following conditions:

- 1) **Full estimated co-payment, co-insurance, and any unmet deductible are due at the time of service according to posted payment policies. The estimated co-payment, co-insurance, or unmet deductible may not be the actual charge once the claim has been processed by the insurance carrier. Patients may receive a refund for over-payment or a balance bill.**
- 2) **Patients must provide insurance card and photo identification at each visit.**
- 3) **Patients are fully responsible for obtaining any necessary referral before the appointment time.**

Although the practice staff makes every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will fully or partially pay a claim. The insurance carrier makes the payment determination, based upon the plan’s level of coverage and associated policies, upon receiving the claim.

I hereby request the direct payment of medical benefits be made to David M. O’Neil, M.D. and Gynemed Surgical Center (which are two separate entities) for any services rendered to me. I authorize any holder of medical information about me to release this information to my insurance carrier or its intermediaries, to the Health Care Financing Administration and its agents, to my attorney, or to another physician’s office.

I understand that because these services are performed for me, I am financially responsible for all charges whether or not paid by my insurance carrier. If payment is fully or partially denied, I understand that my insurance carrier expects the practice to bill me directly for services rendered, and I agree to be personally and fully responsible for payment. If I fail to pay the balance of my account in a timely manner, I understand that my account may be turned over to a collections agency. I agree to pay all costs associated with this action including collection fees, attorney fees, and court costs.

Patient Signature: _____ Date: _____

Gynemed Surgical Center Schedule of Common					
CPT Code	Description	Charge	Charge	CPT Code	Description
99203	Office Visit	95.00	59840	Surgical D & C	500.00
76830	Sonogram, TV	90.00	56302		
36415	Venipuncture	25.00	-----	Facility Fee	850.00
86901	Rh Typing	15.00	99212	Follow-Up Visit	45.00
90782/J2790	RhoGam injection	140.00			

The actual amount paid by an insurance carrier will be based upon the plan’s coverage level and contracted fee schedule. Please refer to your Explanation of Benefits (E.O.B.) for payment information.

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Gynemed Surgical Center Driver Verification Consent

Date: _____ Name of my driver: _____

Relationship: _____ His/her cell number: _____

IMPORTANT, Please read carefully.

If my driver has not accompanied me to my appointment than Gynemed Surgical Center will cancel my appointment. In the event that my driver is not present at the time of my discharge I will wait until my driver arrives. Upon my drivers arrival, he/she must come to the facility to pick me up in order for me to be discharged. If I need to take a taxi I must be accompanied by a trusted person who has come with me to my appointment.

I understand that I should not drive 24 hours following a surgical procedure. I understand that driving while medically intoxicated is viewed the same as driving under influence of alcohol and drugs. I understand that I can be arrested for driving while medically intoxicated. I understand that I can injure or worse, kill another person on the road while under the influence of medications.

I understand I will not be allowed to leave the office by myself, or drive a car. There will be no exceptions. I understand Gynemed Surgical Center will not perform any surgical procedure without confirmation of a driver.

I, _____ (print name), on my behalf and on behalf of my heirs, personal representatives, successors and assigns hereby release and hold harmless Gynemed Surgical Center from and against any claim for injury, including death, or loss or damage to my personal property that may be sustained by me during travel to my destination upon leaving the facility and 24 hours from departure of the facility. This release extends to any and all claims I have or may have against the release parties.

I hereby state and represent that

- I was not under the influence of any medication when I signed this agreement.
- I was of sound body and mind when I signed this release.
- I fully understand the risk and dangers inherent in driving within 24 hours of my procedure.
- I expressly agree to assume the entire risk of any personal injury, including death, which I might suffer as a result of driving within 24 hours of my procedure.

If any provision of this waiver and release shall be declared by a court of competent jurisdiction to be invalid or unenforceable, the remainder of this waiver and release shall not be affected thereby and shall be enforced to the fullest extent permitted by law.

By signing below, I disclose that I have read, understand, and agree to the terms and conditions stated herein.

Signature of Patient

Signature of Driver

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Gynemed Surgical Center – Patient Easy-Pay Consent-

In the event a balance is owed after your claim has been submitted your insurance company, the Easy-Pay system allows for a convenient and safe way to pay off the balance without the hassle of monthly balance reminders and collection notices which can affect your credit. PLEASE NOTE, your card will only be charged in the event your claim is unpaid and will never exceed the Self-Pay price(s) as listed below.

I, _____, authorize Gynemed Surgical Center, to charge my credit card for the balance of charges not paid by my private insurance or medical assistance.

THIS FORM IS OPTIONAL

Self-Pay Discounted Price List

ESSURE : \$2400

Medical Procedure (by pill): \$430.00

Surgical Procedure:

5-14.6 Weeks: \$400.00

15-16 Weeks: \$800.00

16.1-17 Weeks: \$950.00

17.1-18 Weeks: \$1150.00

18.1-19 Weeks: \$1600.00

19.1-20 Weeks: \$1800.00

20.1-21 Weeks: \$2000.00

21.1-22 Weeks: \$2200.00

*Surgical procedure discounted prices include sedation, sonograms, antibiotics, and lab tests.

Patient Name:		
Card Holder's Name (if different from patient's):		
Card Holder's Address:		
City:	State:	Zip Code:
Debit/Credit Card Number: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express		Expiration Date:

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Gynemed Surgical Center Medication Form

INSTRUCTIONS: Please provide us with any and all information regarding your use of prescription drugs, over (OTC) medications (e.g. Tylenol, Advil), dietary supplements, eye drops, nasal sprays etc that you are using on either a long or short term basis. If you are not taking any prescription medications or OTC medications leave the space below blank.

(Please write on the back if you need more room)

If you are allergic to any medications please list them here (including latex):

- I do not have any allergies to any medication that I am aware of

Please list medications that you take daily:

Medication Name & Dose	Route (mouth, eyes, etc)	Frequency (How Often)	Last Dose Taken (Date & Time)

Reconciliation of Medication List- **FOR STAFF USE ONLY**

Medications listed above are okay to take with medication given to you from Gynemed.

Medication Name & Dose	Route (mouth, eyes, etc)	Frequency (How Often)	Last Dose Taken (Date & Time)
<input type="checkbox"/> AMOXICILLIN 500MG	By mouth	3x daily for 7 days	N/A

Patient Signature: _____ Date: _____

Staff Signature: STEPHANIE R Date: 6/25/2014

Physician Signature: DC Date: 6/25/2014

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HEALTH HISTORY

Your complete and honest health history is necessary to provide you with the best medical care.

GENERAL HEALTH HISTORY (please explain all “yes” answers in the spaces provided)

Do you have any allergies? NO YES _____

Have you ever had a reaction to anesthesia? NO YES _____

Are you currently under treatment by any other doctor? NO YES _____

Are you taking methadone or suboxone? NO YES Dose _____

Have you taken any prescription or any other drugs today or within the last week? NO YES _____

Have you taken any muscle relaxers, sleeping pills, pain pills or anxiety medications in the last year? NO YES

If Yes, please list medication, how many taken and length of use: _____

Do you smoke? NO YES How many cigarettes per day? _____ For how many years? _____

Do you consume alcohol? NO YES How many drinks per week? _____

Please CIRCLE if you have ever, in the past or present, had any of the following:

- | | | |
|-----------------------------|-----------------------------|-------------------------|
| Anemia | Epilepsy / Seizures | Sickle Cell Disease |
| Asthma / Hay fever | Emotional Problems | Shortness of Breath |
| Bladder / Kidney Infections | Gall Bladder / Appendicitis | Stomach Pain / Ulcers |
| Bleeding Problems | Frequent Headaches | Swollen Feet / Ankles |
| Blood Transfusion | Heart Murmur | Surgery |
| Blood Clots / Phlebitis | Hepatitis / Jaundice | HIV/AIDS |
| Cancer | High Blood Pressure | Fainting / Dizzy Spells |
| Chest Pain | Hospitalization | Drug Abuse/ Addiction |
| Diabetes | Rheumatic Fever | Stroke |

Do you have any other health conditions of which we should be aware? NO YES

If Yes, please describe: _____

FAMILY HEALTH HISTORY

Please circle if any of your immediate family members (mother, father, brothers, and sisters) have ever had:

- | | | |
|-------------|-----------------------------|------------------|
| Blood Clots | Genetic problems | High cholesterol |
| Cancer | Heart Attack/ Heart disease | Osteoporosis |
| Diabetes | High Blood Pressure | Stroke |

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GYNECOLOGICAL HEALTH HISTORY

Age of First Period: _____ Are you periods regular? YES NO Days of Flow: _____
Cramps: None Mild Moderate Severe Relieved by: _____
First Day of Last Menstrual Period: _____ Normal? YES NO
Have you ever had an internal pelvic examination? YES NO
Last exam / Pap smear: _____ Was it normal? YES NO
Have you ever had an abnormal pap smear? NO YES When: _____ Treatment: _____
Have you ever tested positive for a sexually transmitted infection? YES NO
If yes, Please list the type of infection and when it occurred: _____
When was your last mammogram? _____ Was it normal? _____

PREGNANCY HISTORY

Number of previous pregnancies: _____ History of twin / multiple pregnancies: NO YES
Number of live Vaginal births: _____ Month/Years: _____
C-Sections? _____ Month/Years _____ Complications/Premature: _____
Number of miscarriages: _____ Month/Years: _____ D&Cs? _____
Number of abortions: _____ Month/Years: _____ Any 12+ weeks? _____
Number of ectopic pregnancies: _____ Month/Years: _____ Rupture? _____
How many living children do you have? _____

CONTRACEPTIVE HISTORY

Were you using contraception when you became pregnant this time? NO YES Type: _____
Have you ever used any of the following birth control methods?
_____ Birth Control Pill _____ Nuvaring _____ Patch _____ Depoprovera (Shot)
_____ Implanon/Norplant _____ Mirena _____ Paragard (copper IUD)
_____ Condoms _____ Spermicide _____ Diaphragm _____ Withdrawl
_____ Other: _____

What method of contraception do you plan to use in the future? _____

The patient's medical /surgical history reviewed by attending physician _____

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INFORMED CONSENT for SURGICAL ABORTION

Initials

_____, I, _____, am _____ years old, and was born on _____. I hereby request and consent to have a surgical abortion by the providers of Gynemed Surgical Center. I fully understand that the purpose of this procedure is to end my pregnancy. This is my personal decision, and no one has coerced me or compelled me to make this decision.

_____, I understand that the alternatives to the abortion procedure are parenting and adoption. I also understand that if I am less than 9 weeks that I can choose a medical abortion as an alternative to a surgical abortion. I choose a surgical method for my abortion.

_____, ***I am under eighteen years of age.***

I understand that if I require emergency hospital treatment, my parent(s) or legal guardian may be contacted.

Name of parent / legal guardian: _____

Street Address: _____ City / State: _____

Telephone Number: _____

Gynemed Surgical center encourages young women to discuss their pregnancy and options with a parent, relative or trusted adult. Under 1992 state law, the parent(s) of women under age 18 must be notified before an abortion is performed, unless specific conditions exist (see below).

- Parent has accompanied their minor daughter to Gynemed Surgical Center and acknowledges minor's abortion decision.

Parental Acknowledgement: I hereby acknowledge that I am fully aware that my daughter has requested an abortion and that the physician intends to perform an abortion.

Signature of parent / legal guardian: _____ (relationship : _____)

- In Accordance with Maryland State Law, minor's **parent has not been notified** of patient's intention to have an abortion because:

- The minor is mature and capable of giving informed consent to an abortion
- Notification would not be in best interest of minor
- Notice may lead to physical or mental abuse of minor
- Minor patient does not live with parent or guardian

Minor Patient's Signature _____

Witness Signature _____

Physician's Signature _____

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_____ I understand that a surgical abortion is a very safe procedure but there are risks with any medical procedure. I understand that risks may be higher if I have had a C-section, multiple pregnancies or abdominal surgery. I understand that complications with surgical abortion are uncommon but could include the following:

- **Laceration (tearing) of the cervix:** A small tear in the cervix that may require stitches.
- **Continuing pregnancy:** Which may be due to multiple pregnancies, double uteri, or ectopic pregnancy. A second procedure would be required, and an ectopic pregnancy may require hospitalization and treatment.
- **Incomplete abortion:** There may be tissue left inside the uterus which may cause bleeding or infection. A second suction procedure may be required.
- **Hematometra:** A collection of blood in the uterus. It may require medications or a second suction procedure.
- **Infection:** Which may require antibiotic therapy and very rarely can lead to the loss of childbearing capacity.
- **Perforation:** Sometimes the instruments may go through the uterus which may include damage to internal organs (bladder and bowel). Hospitalization may be required and surgery may be necessary. Rarely, it may be required to remove the uterus which will result in infertility.
- **Hemorrhage:** Heavy bleeding which may require further evaluation and treatment including a possible blood transfusion. Rarely, the uterus may have to be removed.
- **Reaction to anesthesia and/or medications:** resulting in shock, convulsions, or death.
- **Emotional problems:** Although most women report relief, some women may experience depression or guilt following an abortion. Our staff is available to help women deal with these feelings or provide appropriate referrals.
- **Scar tissue:** Scar tissue can occur in the cervix which is called cervical stenosis and may require repeat dilation. Scar tissue in the uterus is referred to as Asherman's Syndrome and may result in the inability to have children.
- **Death:** There is a risk of death with any surgical procedure. The risk of death from an abortion is very rare. The risk increases the longer you are pregnant. The risk of death from a full term pregnancy or childbirth is higher.

_____ I consent to the administration of Misoprostol (Cytotec), whose purpose is to soften and dilate my cervix to facilitate the abortion process. I understand that Misoprostol can cause cramping, nausea, vomiting, diarrhea, and /or vaginal bleeding. I understand that Misoprostol can cause birth defects and once I take the medication, I am agreeing to complete the surgical abortion.

_____ I understand that no guarantees about my future fertility can be offered to me, and no such guarantees have been made to me. I understand that there is evidence that women who have more than three induced abortions may be at increased risk for premature labor.

_____ I understand that the products of conception will be removed during the abortion, and I consent to their disposal by Gynemed Surgical Center in a manner they deem appropriate.

_____ Do you currently have a **Living Will** or **Advanced Directives** in place, **YES OR NO** Please be advised that Gynemed Surgical Center does **NOT HONOR LIVING WILLS or ADVANCED DIRECTIVES**.

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_____ I consent to the exchange of medical records between Gynemed Surgical Center and any other provider, physician, hospital, or clinic pertaining to my medical treatment.

_____ I agree to follow the instructions given to me regarding post-operative care and I agree to return for a follow-up visit. I agree to call Gynemed Surgical Center regarding any questions or problems that arise after my abortion procedure.

In the event of an emergency, I authorize the physician at Gynemed Surgical Center to provide emergency care using his / her medical judgment, including transfer to a local hospital. I understand that patient confidentiality cannot be preserved if transfer to a hospital is necessary.

In the event of an emergency, I authorize Gynemed Surgical Center to contact the following individual:

Name: _____ Relationship: _____

Street Address: _____ City / State: _____

Telephone Number: _____

_____ I understand that I would be financially responsible for any expenses arising from complications from the abortion procedure. I understand such complications can be caused by my own condition or conduct and through no fault of the physician.

_____ I understand Gynemed Surgical Center has the right to refuse me services for whatever reason they deem appropriate.

I have read and understand the above information including PATIENT RIGHTS AND RESPONSIBILITIES. I understand the above risks and accept these risks. I consent and request that a surgical abortion be performed.

Patient Signature: _____

Date: _____

Physician Signature: DC _____

Date: 6/25/2014 _____

Witness Signature: STEPHANIE R _____

Date: 6/25/2014 _____

Translator Signature: _____

Date: _____

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Informed Consent for Moderate Sedation

Our aim is to make your procedure as comfortable as possible. In addition to moderate sedation, your options for pain relief during your procedure include: Local anesthesia which is a numbing medication injected into your cervix to decrease the pain of the opening of your cervix. Mild Sedation which is a pill to decrease your anxiety.

Moderate sedation is the administration of medications to help you relax and decrease the pain of the abortion procedure.

The medications we use include both oral and intravenous medications. You will be given a pill called alprazolam that will help you relax and enhance the effects of the injectable medications. Immediately prior to your procedure, you will be given remifentanyl, which is a pain medication, and midazolam, which is a medication to help you relax.

During the procedure, you will be awake and able to respond to our instructions. The medications will cause you to feel sleepy and decrease the pain of the procedure. Occasionally, the medications may give you an amnesia effect and you may not remember what happened during or immediately after the procedure.

The risks of moderate sedation include: failure to decrease discomfort, severe allergic reaction, phlebitis (inflammation of a vein), respiratory depression or arrest, cardiac arrest, stroke, death

The medications may also cause some side effects, which include: drowsiness, dizziness, amnesia, decreased coordination and mental function, decrease in inhibitions, nausea, vomiting, discomfort during injection

Our staff is trained in the administration moderate sedation` and in emergency procedures. You will have qualified staff monitoring your vital signs and level of consciousness until it is safe for you to be discharged.

You must have a responsible adult to escort/drive you home from the facility today. Also, for the next 12-24 hours, you **must not** drive, operate machinery or make important decisions.

I, _____, give voluntary consent for the physicians of Gynemed Surgical Center to provide me with moderate sedation. I have been informed of the benefits, risks, and side effects of the medications being used. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have discussed with my clinician all medications and/or substances used within the last 24 hours. I have not had anything to eat or drink in the last 8 hours.

Patient Signature

Date

Witness

Date

Interpreter

Date

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Please mark the concerns you have today:

- I don't understand how an abortion is done
- I'm wondering how I'll feel after
- I'm not sure of my decision
- I'm worried about how to avoid getting pregnant again
- I'm afraid people will find out / judge me
- I know I will regret the abortion
- I'm worried I won't be able to get pregnant when I want to
- Will this hurt?
- My relationship with my partner or family
- Possible complications during and after the abortion
- I don't have anyone to talk to about it
- Other: _____

1. Circle all the words that describe how you feel:

Sad	Happy	Angry	Trapped	Confident
Lost	Nervous	Selfish	Helpless	Irresponsible
Mean	Comfortable	Worried	Nauseated	Disappointed
Scared	Powerful	Relaxed	Ashamed	Resolved
Hungry	Relieved	Numb	Guilty	

2. What is the name of the person who came with you today? _____

3. Was this decision difficult or easy for you? _____

4. Whose decision is it for you to have this abortion? _____

5. Have you discussed this decision with anyone? If so, whom? _____

6. Does the man involved know about your decision? If so, is he supportive? _____

7. What are your thoughts about ending this pregnancy? _____

8. Have you had any difficult experiences with pregnancy in the past? _____

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You will fill this part out during individual counseling with your counselor:

The following information has been discussed with the patient

___ The patient has considered all her options: abortion, adoption, and giving birth

___ The patient has made her own decision to have an abortion and expresses confidence in that decision

___ We discussed the procedure, aftercare, and prescriptions

___ We have discussed birth control methods

I, _____, have been informed of all the information listed above.
Patient Signature

I, _____, have discussed the above information with the patient.
Counselor Signature

Counselor Notes: _____

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COMBINED HORMONAL CONTRACEPTIVE METHODS (CHCM) CONSENT FORM

This fact sheet explains the good things and the possible problems of CHCM. If you do not understand all the information, or if you have any questions, please ask your clinician/counselor.

What is it? CHCM include the birth control pill, the birth control vaginal ring, and the birth control patch. They are safe and effective methods of birth control. They are methods which must be used correctly and consistently. You should choose one of these methods of birth control only after reading this fact sheet and discussing your birth control needs with a counselor.

How do CHCM prevent pregnancy?

Each of your ovaries contains thousands of unripe eggs. About half way between the start of one period and the start of the next period, an egg ripens and is released into the tube of the uterus. This is called ovulation. CHCM prevent this from happening. The hormones also thicken your cervical mucus so sperm are not able to swim through it.

Who may take CHCM? Most women can safely use these methods throughout their reproductive years as long as they do not have specific medical problems which would create a health risk.

Who should not take CHCM?

You should not use these methods if:

- you are or suspect you may be pregnant
- you have abnormal vaginal bleeding that has not yet been evaluated
- you presently have serious liver disease
- you have ever had any kind of growth in the liver
- you are being treated for or have a history of cancer in the breast
- you have a lump in the breast that has not yet been evaluated
- you are being treated for or have a history of any estrogen-dependent cancer
- you are being treated for blood clots in the body or have a history of ever having a blood clot/hypercoagulability (Known thrombogenic mutations (e.g. Factor V Leiden, Prothrombin mutation, Lupus Anticoagulant, Protein C, Protein S and Antithrombin deficiencies)
- you have ever had a stroke
- you are 35 years of age or older and you smoke cigarettes

- migraine with aura or neurological change

If you now have or have had a health problem such as migraine headaches, heart disease, high blood pressure, diabetes or gallbladder disease, or are a heavy cigarette smoker, tell your clinician so that she or he may decide if it is safe for you to take these methods. Each of these problems can be made worse by the use of CHCM.

It is known that if a woman smokes cigarettes while using CHCM, she is at higher risk of medical problems. Therefore, women who use these methods are advised not to smoke.

COMMON PROBLEMS

CHCM can have side effects in some women. Fortunately, the side effects are usually not serious. While taking these methods the following problems could occur:

MINOR PROBLEMS

- nausea
- spotting between periods
- less menstrual bleeding
- breast tenderness
- weight gain
- headaches
- depression
- high blood pressure
- darkening of the skin or face
- worsening of acne
- hair loss or increase in hair growth
- decreased sex drive

MAJOR PROBLEMS

- blood clots of the leg or lung (risk is less than that of being pregnant)
- stroke or heart attack
- liver tumors
- gallbladder disease

How effective are CHCM? If CHCM are used perfectly (as directed and other instructions are followed), only about 1 in 1,000 women may become pregnant within the first year. CHCM are only effective while you are taking them. As soon as you stop taking these methods you are no longer protected from pregnancy

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breast milk. Some experts advise against CHCM while breast feeding if other options are available.

BENEFITS

Many women experience the following benefits from using these methods:

- decreased menstrual cramps
- decreased menstrual bleeding
- more regular menstrual bleeding
- decreased pain at the time of ovulation
- improvement in acne
- less risk of developing ovarian and/or endometrial cancer
- less risk of developing benign breast tumor and/or ovarian cysts
- some women note a reduction in PMS

- Lack of protection against STDs. While CHCM are a highly-effective, convenient methods of birth control, they do not provide any protection against sexually transmitted infections such as gonorrhea, chlamydia, or HIV (the virus that causes AIDS). If you or any of your sexual partners have other partners, it is very important to use a latex condom every time you have sex in order to protect yourself against these infections.

PRECAUTIONS YOU SHOULD TAKE

Tell any health care provider that you see that you are using CHCM.

REPORT ANY NEW OR UNUSUAL MEDICAL PROBLEMS TO YOUR CLINICIAN RIGHT AWAY

Other medical drawbacks and risks:

- Between 1% and 2% of women will not menstruate for 6 months or more after stopping CHCM. If you do not have your period, return to the clinic for a pregnancy test.
- If your periods are irregular prior to taking pills, they may again become irregular after you stop these methods.
- The estrogen hormone in these methods slightly decreases the quality and quantity of

When using these methods, you should call your clinic right away if you have any of the following:

- numbness or severe headaches which are not tension headaches and are not relieved with aspirin
- severe leg pain (calf or thigh; usually one leg)
- severe chest pains, shortness of breath eye problems; blurred vision, flashing lights, or blindness
- severe abdominal pain

Please read each of the listed items below.

I understand the side effects, risks, and benefits in using combined hormonal contraceptives. I have also been explained other alternative methods of birth control.

I have read the above statement about Combined Hormonal Contraceptive Methods and have had the opportunity to ask questions.

I wish to receive a combined hormonal contraceptive method.

I understand the side effects and risks of using combined hormonal contraceptives while smoking and still request to receive CHCM.

Complete the spaces below.

Patient: Date _____

Name (please print) _____ Signature _____

Witness: I was present when this form was orally explained, in detail, to this client. To the best of my knowledge and belief, this client understands the information contained in this form. If the client is a minor, I have assessed the client's conduct and sexual relationships and I believe the client to be a mature minor.

Date _____

Name _____ STEPHANIE R _____ Signature _____

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How to Take Care of Yourself at Home

Your body will recover from the abortion very quickly. It is important to take good care of yourself once you are discharged from our care. This information sheet will provide you with guidance on this care.

Bleeding:

- The bleeding that is experienced after an abortion is very individual. It is normal to have no bleeding at all or a range of bleeding from very light to heavier than a normal menstrual period. Bleeding usually lasts 5-7 days but irregular bleeding may continue until your next menstrual period.
- It may take up to 5-8 weeks for your regular menstrual cycle to return.
- You may notice a discharge after your abortion that looks like coffee grounds or a small clump of tissue. This is Monsel's solution. It is used to control bleeding after the procedure.

Pain:

- It is normal to have mild discomfort after your abortion.
- You can use over-the-counter pain relievers for relief of the discomfort. Generally, Ibuprofen and naproxen sodium work very well for cramps. If you are unable to take that, acetaminophen is also an option. The amount depends on which medication you are using:
 - Ibuprofen 800mg every eight hours. Over-the-counter brands (Advil and Motrin) contain 200mg per pill. You can take four of the over-the-counter every 8 hours.
 - Naproxen Sodium 500mg every 12 hours. Over-the-counter brands (Aleve) contain 220mg. You can take two every 12 hours.
 - Acetaminophen 1000mg every 4-6 hours. Over-the-counter brands (Extra Strength Tylenol) contain 500mg per pill. Do not take more than 8 pills in a 24 hour period.
- You may have mild discomfort at the site of your IV. Warm moist compresses will help relieve the discomfort.

Diet:

- You may resume your normal diet. Please do not drink any alcohol for 24 hours.

Activity:

- Rest and light activity for the rest of today.
- You may return to your normal activity tomorrow. You may return to work or school.
- Do not do any heavy lifting or vigorous activity for one week.
- Please do not have sexual intercourse until your follow-up exam.

Hygiene:

- Do not take tub baths for 2 weeks. You may shower as often as you would like.
- Please do not use tampons or douche for the first two weeks after your procedure.

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Sedation precautions:

- The effects of the medications can last for up to 24 hours after your procedure. These feelings can include: sleepiness, blurry vision, unsteady gait, nausea and vomiting.
- Do not drive, operate heavy machinery or make important decisions for the next 24 hours.
- Do not take any medications that have a sedating effect. This includes: allergy medications, sleep aids, and prescription pain relievers.

Medications:

- You will be given antibiotics to prevent infection. Please take them as directed and finish all of the pills.
- You may be given birth control to start after your abortion. Please refer to the birth control fact sheet for those instructions.

Follow-up:

- It is important to return to our office for your follow-up visit. You can schedule this visit before you leave or call our office at your convenience.
- If you are unable to return to Gynemed for your follow-up, please schedule an appointment with your routine gynecologist for this care one week after your abortion.

Please contact us at 410-391-1000 immediately if you experience:

- Fever of 100.4 or greater.
- Soaking 2 maxi-pads an hour for more than 2 hours in a row.
- Passing blood clots larger than the size of a half-dollar.
- Severe pain that is not relieved with pain medication.

If you are unable to contact us and feel like you are experiencing a life-threatening emergency, please call 911 or go to the nearest emergency.

I understand the above information regarding my care. I have had the opportunity to ask questions. I am being discharged to a responsible adult who will drive me home.

Patient/Responsible Party Signature

Date

Staff Signature

Date

MD Signature

Date