**ULTRASOUND ACKNOWLEDGEMENT AND INFORMED CONSENT**

I, _____, consent to have an ultrasound performed by BSSI to determine the probable gestational age of the pregnancy at the time of my termination of pregnancy. The cost of the ultrasound is $250 and not refundable. It is applied toward the payment of the termination. (**The ultrasound image cannot be copied, duplicated, or provided.)** It is used for fetal aging only.

**(Please initial)**

_____ I understand and acknowledge that if I decide to not terminate this pregnancy, the staff and physicians of BSSI are not responsible for any further care that I may require or desire and does not constitute his/her responsibility as my attending physician.

_____ I understand and acknowledge that in accordance with Florida law, it is required that a Physician, (or other qualified person), perform an ultrasound and inform a patient seeking to terminate a pregnancy of the probable gestational age of the fetus, and be offered the opportunity to view contemporaneous ultrasound images and have them explained.

_____ I understand and acknowledge that I have the opportunity to view the ultrasound images and hear an explanation.

_____ I understand and acknowledge that in the event the pregnancy is over 13 weeks LMP (last menstrual period) and/or is a multiple gestation, I will be notified of this information.

**(Please circle either YES or NO for each of the following)**

1. **YES NO** I request to view the ultrasound image.
2. **YES NO** I request to hear an explanation of the ultrasound results.

I certify the decision to view the images or hear the explanation were not based on any undue influence from any person to discourage me from doing so. This decision was made of my own free will.

_____ _____

Patient Signature Date

_____ _____

Staff Witness Date

**To be signed with Authorized Medical Provider: (Please initial your choice)**

_____ I have decided to opt out of viewing or hearing the ultrasound images.
_____ I have received and I am satisfied with the viewing and/or explanation of the ultrasound.
_____ "Fetal Development and Alternatives to Terminating a Pregnancy" printed materials from the Florida Department of Health have been made available to me.

**A physician orally and in person informed me of:**

_____ The nature and risks of the abortion procedure I am considering having.
_____ The risks of carrying to term.
_____ The estimated gestational age of the fetus, verified by ultrasound today, and at the time of my projected appointment.
_____ I understand that if the abortion date is postponed, I must add on each additional day to the probable gestational age of the fetus.

_____ _____

Patient Signature Date

**I herby certify that I have orally and in person informed this patient of the above.**
**( ) Medical Abortion ( ) Surgical Abortion ( ) Second Trimester Abortion.**

_____ _____

Authorized Medical Provider Signature Date

# PATIENT INFORMATION SHEET

Name: _____ Phone (Cell): _____

Address: _____ Phone (W) (H): _____

_____ Age: _____ DOB: _____
City State Zip

Email address: _____

Have you been our patient before? _____ Social Security#: _____

Who referred you to our office? ☐ Friend/Relative ☐WEN/NAF ☐Internet

Your Doctor? ☐Dr.'s Name: _____ Other? _____

**YOUR PHARMACY** :_____**PHONE NUMBER/ CROSS STREETS**: _____

**Emergency Contact #1:** _____ **Relationship:** _____ **Phone:** _____
**Driver Name and Phone, if different from above, Name:** _____ **Phone:** _____
**Emergency Contact #2:** _____ **Relationship:** _____ **Phone:** _____

**(Please Initial)** _____ I authorize BSS International Inc., hereinafter referred to as BSSI, its physicians, and staff to speak to my emergency contacts and/or driver. If for any reason BSSI, its physicians and staff, or any entity acting on their behalf attempt to contact me and are unable to do so, I authorize the contacting of myself or any of my emergency contacts via telephone or postal mailing address provided. This includes any and all attempts at debt collecting.

---

## PLEASE CHOOSE **ONE** OPTION. INITIAL **ONE** ONLY

Failure to disclose this information today will result in waiver of insurance claim and monetary refund.

PLEASE COMPLETE THIS SECTION IF **YOU HAVE <u>NO HEALTH INSURANCE</u>:**

_____ I am hereby stating that I am currently uninsured. I have no active medical health insurance coverage or any pending medical/health insurance, which may have a retroactive effective date resulting in active coverage for today. I agree that it is my full responsibility and obligation to inform the office staff of my true and accurate insurance status PRIOR to any medical care I receive today, or in the future. I understand that no insurance claims will be filed by this office or myself due to my failure to provide true and accurate insurance coverage information, AND HAVE NOT PROVIDED ACCURATE INSURANCE COVERAGE INFORMATION IN WRITING prior TO SERVICES BEING RENDERED UPON ME.

***OR***

PLEASE COMPLETE THIS SECTION IF **<u>YOU HAVE HEALTH INSURANCE BUT ARE NOT USING IT TODAY</u>**

_____ Due to the sensitive nature of the services provided, I hereby request to waive all of my rights to file an insurance claim. BSSI will not accept assignment for medical care provided to/upon me, BSSI or any member of its medical staff. I have been advised that today's medical service may be a benefit covered by my current health insurance. I choose to pay for it, and all associated medical costs in full, prior to the services being rendered. I do not want this office to contact my insurance provider or furnish them with any information. This decision is irrevocable.

***OR***

PLEASE COMPLETE THIS SECTION IF **<u>YOU HAVE INSURANCE AND ARE USING IT HERE TODAY</u>**

_____ In consideration of services rendered hereby irrevocably assigned transfer to BSSI all rights, title and interest on the benefits payable for services rendered BSSI or their agents provided in the above mentioned policy. I hereby authorize the insurance company herein listed above to pay directly to BSSI, all benefits due under said policy(ies) by reason of services rendered therein. I will pay BSSI for all charges incurred or alternatively for all charges in excess of the sums actually paid pursuant to said policy(ies) A Photostat copy of this authorization shall be as valid as the original

Insurance Co: _____ ID#_____ Group_____
Insured's Name: _____ Relationship to Patient: _____ Date of Birth_____

---

*TO BE COMPLETED AND SIGNED WITH THE PATIENT EDUCATOR*

☐ *MEDICAL* ☐ *1ST TRIMESTER* ☐ *D&E*

*Options Explained*
*Informed Consent*
*Anesthesia Risks, Benefits and Side Effects Explained*
*Follow-Up Appointment and Post-Op Instructions given*
*Discussed STDs, HIV*
*D/V Screening*
*Patient comfortable with 1st Trimester medical/surgical abortion procedure*
***After 15 weeks LMP***
*Pt comfortable with 2nd Trimester Procedure*
*Laminaria Consent/Laminaria Instructions*
*Caregiver's correct phone number given*
*Phone number where patient may be reached during the night:*

*Birth Control Discussed, Patient chose:* _____

*Information Given:* _____ *Samples:* _____

☐ *FM* ☐ *R/I* ☐ *FD* ☐ *MH* ☐ *FUNERAL ARRANGEMENTS MADE IN ADVANCE BY PT.*

*Notes:* _____

_____

_____

_____

I have answered all questions to the best of my knowledge and have discussed the procedure, sedation, risks, complications, benefits, and side effects with the advocate. I confirm I did not have anything to eat or drink since _____. I understand that it is my responsibility to have someone drive me home after surgery, and stay with me 24 hours, if I choose anesthesia.

Patient Signature: _____ Date: _____
Patient Educator Signature: _____ Date: _____

## MEDICAL HISTORY

**Your answers are for our records and will be considered confidential**

Name: _____ Date of Birth: _____ Age: _____

### Pregnancy History

Prior Pregnancies: _____ Number of living children: _____ Full Term: _____ Premature: _____
Vaginal Births: _____ Cesarean: _____ Miscarriages: _____ Abortions: _____
Ectopic Pregnancies: _____ Molar Pregnancies: _____ Other Complications: _____

Date of Last Menstrual Period: _____ Your Blood Type (if known) _____ ☐ Positive ☐ Negative

### Gynecological History

**(Please check any you have now or had in the past)**

☐History of STD's: ☐Gonorrhea ☐Chlamydia ☐Trichomonas ☐Syphilis ☐Herpes ☐HIV ☐HPV
☐History of Abnormal Paps ☐Colposcopy ☐Cryosurgery ☐Leep/Cone Biopsy ☐Fibroids ☐Abnormality

### General Health Questions

Are you in good health?..... ☐YES ☐NO _____
Conditions presently being treated: _____, _____, _____
List previous surgeries (and year): _____, _____, _____
Other hospitalizations: _____
Have you had any abnormal bleeding associated with previous surgery or trauma: ☐YES ☐NO
Previous blood transfusions: _____
**ALLERGIES** to any drug or substance ☐YES ☐NO List any and all substances to which you are allergic:
_____
Have you or any family member has history of medical condition ☐YES ☐NO (Who) _____
And What?: _____
Are you taking any medications at this time ☐NO ☐YES **(Please List):** _____,
_____, _____, _____, _____
Do you smoke? ☐YES ☐NO Substance Abuse? ☐YES ☐NO (Type): _____

**Please Indicate Yes or NO for any Conditions even if you no longer have them.**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Heart Disease..... | ☐ | ☐ | Hepatitis..... | ☐ | ☐ | Tumors/Growths..... | ☐ | ☐ |
| Heart Murmur..... | ☐ | ☐ | Diabetes..... | ☐ | ☐ | Infections..... | ☐ | ☐ |
| Mitral Valve Prolapse..... | ☐ | ☐ | Asthma..... | ☐ | ☐ | Swollen Lymph Glands | ☐ | ☐ |
| Congenital Heart Defects | ☐ | ☐ | Shortness of Breath.. | ☐ | ☐ | Emotional Problems..... | ☐ | ☐ |
| Rheumatic Fever ..... | ☐ | ☐ | Lung Disease..... | ☐ | ☐ | Anxiety..... | ☐ | ☐ |
| Heart Attack..... | ☐ | ☐ | Tuberculosis..... | ☐ | ☐ | Psychiatric Care..... | ☐ | ☐ |
| Pacemaker..... | ☐ | ☐ | Emphysema..... | ☐ | ☐ | Frequent Headaches... | ☐ | ☐ |
| Stroke..... | ☐ | ☐ | Liver Disease..... | ☐ | ☐ | Sinus Trouble..... | ☐ | ☐ |
| High Blood Pressure..... | ☐ | ☐ | Seizures..... | ☐ | ☐ | Hives/Rash..... | ☐ | ☐ |
| Low Blood Pressure..... | ☐ | ☐ | Ulcers..... | ☐ | ☐ | Thyroid Disorder..... | ☐ | ☐ |
| Scarlet Fever..... | ☐ | ☐ | Kidney Disease..... | ☐ | ☐ | Epilepsy..... | ☐ | ☐ |
| Chest Pain ..... | ☐ | ☐ | Anemia..... | ☐ | ☐ | Cancer Treatment..... | ☐ | ☐ |

Is there any condition or problem that you think we should know about? ☐YES ☐NO If yes, explain:
_____

**I have read (or have had read to me) the foregoing evaluation and I certify that the information provided above is correct to the best of my knowledge.**

SIGNED BY PATIENT: _____ DATE: _____

**The Following to Be Completed By First and Second Trimester Surgical Patients ONLY:**

**In accordance with Section 383.33625 of the Florida Statutes**, all remains will be handled and disposed of according to its guidelines. Your signature below authorizes our physicians to dispose of fetal remains under the terms customarily used.
_____ I HAVE READ THIS NOTICE. I WILL NOT BE MAKING ANY ARRANGEMENTS WITH A FUNERAL HOME.

**IF YOU INTEND TO HAVE ARRANGEMENTS MADE WITH A FUNERAL HOME, THESE ARRANGEMENTS MUST BE MADE IN ADVANCE, BY YOU. IT IS YOUR RESPONSIBILITY TO COORDINATE WITH THEM, AND TO NOTIFY OUR OFFICE OF YOUR INTENTIONS, AS WELL AS TO PROVIDE US WITH THEIR CONTACT INFORMATION. PLEASE INITIAL IF YOU ARE DOING SO.**
_____ I HAVE MADE ARRANGEMENTS WITH (Name and Phone of Funeral Home): _____

**BSSI**

**For More Information or to Report a Complaint**

If you have questions or want to report a complaint, please contact our Privacy Officer, at (954)720-7777. Complaints may also be filed with the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

I have read this privacy notice and I have been given ample time to ask questions regarding the information it contains. I understand BSSI will hold my record to the highest standard of privacy and confidentiality and will only release my personal health information when authorized by me in writing, or when required by law to do so.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

**Privacy Notice Acknowledgement**

I acknowledge that I was provided a copy of the Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the Notice.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

**Assigned Authorization to Release Medical & Financial Information**

I, _____authorize the office of BSSI to provide complete/full access of my medical and financial information to: (Print Name of person you wish to have access to your records) _____.I understand that by completing this section and signing below, I give my permission for BSSI or any member of its staff to release my personal medical and/or financial information in writing and/or verbally to the person I have listed above. I confirm that my <u>failure to fully complete this section will void authorization</u> to release information.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

**Authorization of Voice Messages Pertaining to Health Information**

By signing below, I authorize BSSI or any member of its staff to provide detailed voice messages in regards to my personal health information and/or financial information at the following telephone number(s): (_____)_____, (_____)_____. I understand that by signing, I authorize that a voice message may be left at the telephone numbers above. These messages may contain but are not limited to laboratory test results, surgical outcomes and prescription/drug information.

**Follow-Up Telephone Call**

Under Florida Law, one of our medical staff is required to call you within 24 business hours of your appointment. However, <u>you may choose to decline this call for privacy or any other reason(s).</u>
Please **INITIAL ONE** of the following:

_____ DO NOT CALL ME.

**OR**

_____ I CONSENT TO A TELEPHONE CALL from BSSI or any member of its staff. The telephone number to reach me is: (_____) _____Ext: _____.
If I do not answer the telephone, no voice message is to be left and no additional attempts are to be made.
**<u>(If you have caller ID, the name and phone number of BSSI will appear).</u>**

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

**AFFIRMATION: 18 Years of Age or Older**

I hereby declare and affirm that I am **18 YEARS OF AGE OR OLDER** and therefore am not affected by the State of Florida Parental Notification Law. I understand that affirmation by providing my signature below becomes a legal document and I may be subject to criminal prosecution if provided falsely.

_____ _____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE DATE

**MINORS ONLY (18 Years of Age or Younger): Please INITIAL ONE:**

_____ I am accompanied by my parent or legal guardian
**Name:** _____ **Relationship:** _____

**OR**

_____ I have obtained **A JUDICIAL WAIVER (BYPASS)**, and will provide it.

**OR**

_____ I am an **EMANCIPATED MINOR** / have court order, and will provide it.

**BSSI INFORMED CONSENT TO PREGNANCY TERMINATION WITH IV SEDATION**
**(Please Initial)**

_____ 1. I _____ age _____. Request and consent to the performance upon me of a pregnancy termination procedure, suction, D&C, D&E, by a designated associate physician at BSSI, BSS International, Inc. (hereinafter called "the Center") at 7777 North University Drive, Tamarac, Florida.

_____ 2. I hereby request and authorize BSSI and its designated physicians, to perform upon myself the procedure known as:

**□ Elective Termination of Pregnancy or □ Therapeutic Termination of Pregnancy**

_____ 3. The purpose of the procedure is to terminate my pregnancy, and I affirm that I have personally chosen pregnancy termination in light of the alternative of continuing with the pregnancy to term. No member of the staff and no one else has coerced or compelled me to terminate the pregnancy at the Center.

_____ 4. I further consent to the taking of cultures and the performance of reasonably indicated tests and procedures in addition to pregnancy termination/surgical treatment of fetal demise, whether or not relating to presently known conditions, if my medical attendants find this necessary or advisable in the course of evaluation of treatment, for management of complications or otherwise.

_____ 5. I hereby acknowledge that I have read and fully understand an attached sheet entitled "Important Information Which Every Patient Should Know Concerning the Termination of Pregnancy Procedure" or "Important Information Every Patient Should Know Concerning the Termination of Pregnancy/Surgical Treatment of Fetal Demise Procedure(s)." I fully understand and accept the various risks set forth therein, and I have had an opportunity to discuss these risks and all other questions which I may have concerning the pregnancy termination/surgical treatment of fetal demise procedure(s) with a medical doctor. My signature at the end of the information sheet indicates my approval and acceptance of all risks set forth therein.

_____ 6. I understand the nature of the pregnancy termination, the procedure to be performed, and alternatives to this procedure including continuing the pregnancy to term, and/or adoption alternatives. The Center is hereby advising me of the availability of the services of social agencies should I desire to continue the pregnancy to term.

_____ 7. I hereby expressly waive any claim or demand which I, or my representatives, may have of any nature, kind or description against BSSI, its agents or employees who participate in the herein stated procedure. I specifically assume any and all responsibility for the above stated procedure, acknowledging that the same is done at my request for my benefit.

_____ 8. I understand the risks and possible complications of having the pregnancy terminated, including but not limited to, infection, blood clots in the uterus, failed or incomplete abortion (tissue left inside the uterus), perforation (puncture in the uterus, cervix, intestines, bladder), reaction to medications including anesthesia, depression, emotional distress, cervical laceration, amenorrhea (no period, uterine adhesions, bleeding problems, heart and breathing problems, ectopic pregnancy, and any other unforeseeable complications (including increased risks from pre-existing conditions), and very rarely death.

_____ 9. I understand the emotional distress is a potential complication of this procedure. Individual women cope differently with abortion. Most women go through the process with minimal emotional effects, but in some cases, professional help may be required. I understand that I can return to the Center if I need additional counseling and/or referral if this should occur.

_____ 10. I have fully and completely disclosed my medical history, including allergies, blood conditions, heart and/or breathing problems, prior medications or drugs taken and reactions I have had to anesthetics, medicine or drugs. I consent to my physician's reliance on this disclosure as full, accurate and complete.

_____ 11. I consent to the administration of such anesthesia as may be deemed necessary or advisable by my physician or associates.

_____ 12. I understand that a pregnancy termination/surgical treatment of fetal demise procedure requires the removal of the products of conception and other tissue, and I consent to disposal or use of these products and tissue by the physician in any manner they deem appropriate. If I have questions or complications after leaving, I agree to call the physician immediately. I have been provided contact information for the physician. I agree that if I should seek treatment for complications resulting from the termination/surgical treatment of fetal demise procedure from any other physician prior to consulting with the physician, the physician will not be able to assist me further. I understand and agree that the physician is under no obligation to provide me with treatment or hospitalization for complications that arise from the pregnancy termination procedure.

_____ 13. I understand the nature of the post operative recovery period. I understand the list of instructions along with the medications, which I must take. I understand and realize the importance of a follow up appointment and understand it is my responsibility to come to this appointment. I understand I should contact the Center *first* if I have any questions or concerns about my recovery.

_____ 14. I understand that in very rare circumstances, the Center may deem in my best welfare to transfer me to the hospital. I understand in this rare occurrence, I will be held responsible for all bills accrued. I further understand the Center cannot be held for a breach in confidentiality. In emergencies, it is sometimes necessary to contact other individuals.

_____ 15. I understand that I have been advised by the Center to remain in the area of care for two weeks following the termination. I understand if I choose to go against the advice, that I take full responsibility for my care, I agree not to hold the Center, its physicians or any staff liable for any harm or injury that may result from my leaving the area.

I understand this informed consent and the information statement with which I have also been furnished are legal documents and is my desire and agreement that all other parts continue in force, and are binding upon me. These legal documents reflect my wishes, and if any part of these documents is held to be invalid, it is my desire and agreement that all other parts continue in force. I certify that I have thoroughly read and fully understand the above informed consent, and that I agree in light of that consent and the information concerning pregnancy termination procedures which have been furnished to me, the pregnancy termination procedure I have requested.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

STAFF WITNESS DATE

**BSSI**

**IMPORTANT INFORMATION EVERY PATIENT SHOULD KNOW CONCERNING TERMINATION OF PREGNANCY / SURGICAL TREATMENT OF FETAL DEMISE PROCEDURE**

**1. SURGICAL PROCEDURE:** A termination of pregnancy/induction evacuation of fetal demise procedure of any kind is a surgical procedure which, like all surgical procedures of both minor and major importance, involves certain risks to the patient. These risks are outlined below.

**2. PROPER INFORMATION:** The physician who performs a pregnancy termination/induction evacuation procedure must be provided with complete information by the patient in order to correctly evaluate her medical needs and her physical condition. In addition, the physician must be provided with the results of laboratory tests in order to better prepare him/her for performing the procedure. Failure to provide the treating physician with adequate and accurate information may lead to unnecessary complications. Every patient considering any surgical procedure should provide her physician with a complete medical history, including allergies, blood conditions, prior medications, or drugs taken, adverse reaction to anesthetics, medicines or drugs. Patients should also permit their physicians to take any and all other tests which the physician deems advisable for the evaluation or treatment of her care. Of particular importance for pregnancy termination cases is a complete and accurate history of menstruation for the six months prior to the termination procedure.

**3. ANESTHESIA:** Anesthesia is used in most surgical procedures to eliminate or reduce the pain from the performance of the surgical procedure. Anesthesia is not foolproof, and in some cases, the patient will experience pain and discomfort even though anesthesia is administered. In termination of pregnancy/induction evacuation procedures, a local anesthetic will be used along with your choice of an intravenous anesthesia. Anesthesia may result in temporary mental impairment.

- A local anesthetic does not always eliminate pain. In some cases, local anesthetics cause severe reactions, even shock. No guarantee can be given that the use of a local anesthetic will make the pregnancy termination procedure painless or that unfavorable or even severe reactions will not result.
- Conscious sedation may render the patient in a sleep-like state. The patient will become very groggy and in some instances experience nausea. Medications administered are intravenous sedatives and anesthesia agents. Medications may minimize pain, or may not eliminate pain completely each person reacts differently to intravenous sedatives and anesthesia agents.

**4. MANADATORY REQUIREMENT:** I understand that I will be administered anesthesia as part of my surgical procedure. I agree not to drive a vehicle or leave the facility without a licensed driver to assist/drive me home. **I understand that if I violate this requirement, it could result in serious injury or death to myself and to others.** Therefore, if I cannot get a ride from a licensed driver, I will so advise Dr. Michael Benjamin or any of his agents who will assist me in making alternative transportation arrangements at my cost. I hereby acknowledge

**5. COMPLICATIONS IN GENERAL:** The complications associated with pregnancy termination/induction evacuation procedures are generally considered to not be more severe than those associated with childbirth and may be generally less severe than those associated with childbirth. Nevertheless, as with all surgical procedures, there are inherent risks of minor and major complications, including death which may occur without the fault of the physician. No guarantee can be given that complications will not result. With respect to pregnancy termination/induction evacuation procedures, there is a possibility of perforation of the uterus and resulting injuries that could require that a hysterectomy be performed. In some cases, all of the tissue cannot be removed and in such cases, fever, bleeding and infection may occur. Adverse reactions to medicines and anesthesia can also occur and these reactions include pain, cramps, and even convulsions. In rare cases, the contents of the uterus may not be entirely removed and you could continue to be pregnant. The importance of a follow-up exam cannot be stressed enough in order to avoid and care for possible complications. Generally, contraceptives are administered or used after the pregnancy termination /induction evacuation procedure and these contraceptives can themselves result in adverse complications.

**6. FOLLOW-UP EXAMINATION:** In order to minimize the risk of complications from the pregnancy termination/induction/evacuation procedure and to limit the severity of side effects which may occur, a follow-up examination is always necessary. I understand it is my responsibility to seek follow-up care and have been advised to return to BSSI and its designated physicians, other physician of my choice, or other healthcare facility within 2-3 weeks post operatively.

**7. PATIENT'S RESPONSIBILITIES:** The standard of medical practice of any physician is to be judged in accordance with those standards reasonably acceptable to other physicians practicing in similar facilities within the United States. This means that the Physician attending the patient at the Center, while fully qualified to perform the procedure, cannot be expected to have unusual or extraordinary talents, but can be expected to be of the same caliber as other physicians who perform procedures in the medical community.

**8. CENTER'S RESPONSIBILITY:** The center will attempt to maintain a reasonable level of financial responsibility; however, there can be no assurance that the center will maintain or will be able to maintain insurance coverage sufficient to satisfy all claims.

**The undersigned patient acknowledges that she read the foregoing information regarding the termination of pregnancy/induction evacuation procedure and certifies that she fully understands and accepts the risks set forth above.**

_____ _____

PATIENT SIGNATURE DATE

_____ _____

STAFF WITNESS DATE

# BSSI
# PROBLEMS THAT MAY OCCUR

I understand the risks and possible complications of terminating this pregnancy. I understand that some of these problems may be avoided or lessened if I follow the postoperative instructions and care.

**Common Risks and Complications**

Abortion is one of the safest medical procedures performed in the United States. In order to provide you with adequate informed consent, you need to understand the risks and complications.

1. Retained tissue: A small amount of tissue can be left inside the uterus. If this should occur, you should return to this facility. It is also important that you return for your 2-week follow-up appointment.

2. Failed abortion: The procedure will be repeated at the facility at no extra charge. It is important that you return for your follow-up appointment.

3. Infection: Infection is very rare, especially if you follow our post-operative care instructions. You need to call the office if you have a fever over 101.0

4. Ectopic pregnancy: This is a pregnancy that is outside the uterus, usually in the fallopian tube. It is not a complication of abortion, but is something that may occur naturally. If the doctor suspects this, you will be given instructions on what to do next.

5. Heavy bleeding: Very rarely women may experience heavy bleeding after a termination. Again, this can be avoided or minimized by following instructions. You should call if you bleed through a pad in more than one hour.

6. Reaction to medications: This may happen with any surgery. We have other medications that can help if this occurs. It is important that you provide us a complete and accurate medical history.

**Very Rare Complications**

Below is a list of **very rare** complications. Please feel free to ask questions if you need further explanation.

Cardiac arrest
Respiratory depression/arrest
Hemorrhage
Uterine perforation
Injury to cervix and/or uterus
Injury to intestines or bladder
Pelvic infection and/or surrounding tissue, organs
Laparoscopy
Reaction to anesthesia
Blood clots in uterus
Ovarian pain
Septicemia: blood infection
Thrombophlebitis: blood clots in veins
Absence of menstrual periods
Blood transfusion
Hospitalization
Hysterectomy
Aggravation of pre-existing conditions
Any unforeseeable complications
Death (Very rare)

_____ _____

PATIENT SIGNATURE DATE

_____ _____

STAFF WITNESS DATE

**Michael J. Benjamin, MD, FACOG**
7777 North University Drive, Suite 102
Tamarac, FL 33321
Hours: Monday – Friday 8:30am – 5:00pm and Saturdays 8am – 12pm
Tel: (954) 720-7777|Fax: (954) 726-2896

***After Hours, for Emergencies only, call: 954-790-7770***

## Post-Operative Instructions

1. Eat lightly and drink plenty of clear fluids. Fluid intake is important to your recovery.
2. After your surgery, it is important to go home and rest for the duration of the day. No heavy lifting, long walks, or straining.
3. Avoid driving, operating machinery or making important personal or business decisions until the following day.
4. **FIRST TRIMESTER PATIENTS:** Nothing introduced into the vagina for 48 hours. Bathing as usual.
   **SECOND TRIMESTER PATIENTS:** Do not insert anything into the vagina for two weeks. Bathing as usual.
5. You will have medications prescribed which will be sent electronically to your pharmacy., it is important that you fill these prescriptions and that you **TAKE ALL MEDICATIONS AS DIRECTED.**
6. Cramping is normal and may vary from minimal to severe. One of the prescriptions provided is a pain medication. Take it as directed to relieve the discomfort. There will be antibiotics prescribed, please start them today and take until they are finished.
7. You may encounter bleeding in the next few weeks. The bleeding may come and go irregularly, and some patients may have no bleeding at all. This is normal.
8. Call the number above for any of the following:
   - Fever greater than 101 degrees Fahrenheit that persists for more than one hour.
   - Soaking a full size MAXI pad within one hour and/or passing quarter size blood clots or larger.
   - Pain greater than experienced with a severe menstrual period.
   - If you call us, please have **the date of your procedure, your pharmacy phone number, and the number of MAXI pads you have used in the last four (4) hours.**
9. Your first period usually returns in 6 to 12 weeks following surgery if you do not begin on birth control. The bleeding may be heavier, last longer and cramps may be stronger than your usual period. If you began oral contraceptive pills, patch, or vaginal ring, you can expect a period within the last 2 weeks of the contraceptive cycle. Your first period may be much heavier, last longer and be more crampy or painful than usual. Understand that it takes 2 to 4 cycles on birth control before your period becomes regular. You can **begin oral contraceptives on the Sunday following the abortion.**
10. Your breast(s) may become engorged (i.e. sore, tender, fluid filled) and leak within days after surgery: This is NORMAL. There is no medication available to treat breast engorgement. Wear a good support bra 24 hours a day, do not stimulate (squeeze) the breasts. The discomfort may increase slightly before resolving. Take your pain medication and gently apply cool compresses to the breasts as needed for the discomfort.
11. **It is your responsibility to return to this office or your private physician for a post-operative examination if you would like to have one.** The optional postoperative appointment timeframe for your procedure is 2(two)-3(three) weeks. There is no charge to patients for the routine post operative exam if you present **within 28 days** from the date of your surgery. Any non-surgical related examinations or tests not related to the abortion, will be your financial responsibility.

No prescription refills or replacements will be provided after this visit. If you wish to continue your gynecological care with us, please call to schedule your appointment at least two weeks in advance. If you have received surgical and post-operative care only, you **will be a NEW GYNECOLOGY PATIENT**

**Especially for:** _____

**YOUR POST-OP APPOINTMENT: Please call our office to set up your post-op appointment**

**OR**: _____

**Comments/Instructions**: _____

**Michael J. Benjamin, MD, FACOG**
7777 North University Drive, Suite 102
Tamarac, FL 33321
Hours: Monday – Friday 8:30am – 5:30pm and Saturdays 8am – 12pm
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# PATIENT DEMOGRAPHICS

**Patient Name:** _____ **Age:** _____ **Date:** _____

**Number of Previous Live Births:**
Now Living _____ Now Deceased _____ Miscarriages _____ Abortions _____

**Residence of Patient – County and State:**
_____

**Patient Married?**
○ Yes
○ No

**Patient of Hispanic Origin?**
○ No, not Spanish/Hispanic/Latina
○ Yes, Mexican, Mexican American, Chicana
○ Yes, Puerto Rican
○ Yes, Cuban
○ Yes, Other Spanish/Hispanic/Latina
(Specify Country): _____

**Patient Race:**
○ White
○ Asian Indian
○ Chinese
○ Japanese
○ Vietnamese
○ Native Hawaiian
○ Samoan
○ Other (Specify)
○ Black or African American
○ Guamanian or Chamorro
○ Filipino
○ Korean
○ American Indian /Alaska Native
○ Other Asian (Specify)
○ Other Pacific Islander (Specify)
(Specify Country): _____

**Patient Education:**
○ 8th Grade
○ 9th – 12TH Grade, no diploma
○ High school graduate or GED completed
○ Some college credit, no degree
○ Associate's degree
○ Bachelor's degree
○ Master's degree
○ Doctorate or Professional degree

**Reason for Pregnancy Termination:**
○ Elective abortion
○ Abortion performed due to Social or Economic reasons
○ Abortion performed due to Emotional/Psychological health of the Mother
○ Abortion performed due to Physical Health of Mother that is not life endangering
○ Abortion performed due to a Life Endangering Physical Condition
○ Abortion performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality
○ Abortion performed due to Incest
○ Abortion to be performed due to Rape
○ Fetal Demise

**If there are any questions you were unable to answer, please address them with the counselor. Please do not ask at the front window.**