

Please bring your I.D., this packet, and one hundred dollars (\$100.00) cash on this day. This includes your Indiana **State Law Information, Ultrasound, and RH FACTOR** (negative or positive). The one hundred dollar (\$100.00) fee is non-refundable.

INDIANA LAW FORM

- (1) I hereby consent to an abortion.
- (2) At least eighteen (18) hours before the abortion the physician who is to perform the abortion, the referring physician or a physician assistant, an advanced practice nurse, or a midwife to whom the responsibility has been delegated by the physician who is to perform the abortion or the referring physician has orally informed me of the following:
 - a. The name of the physician performing the abortion.
 - b. The nature of the proposed procedure or treatment.
 - c. The risks of and alternatives to the procedure or treatment.
 - d. The probable gestational age of the fetus, including an offer to provide:
 - i. A picture or drawing of a fetus
 - ii. The dimensions of a fetus; and
 - iii. Relevant information on the potential survival of an unborn fetus at this stage of development.
 - e. The medical risks associated with carrying the fetus to term.
 - f. The availability of fetal ultrasound imaging and auscultation of fetal heart tone services to enable me to view the image and hear the heartbeat of the fetus and how to obtain access to these services.
 - g. That before the abortion is performed I may, upon my request, view the fetal ultrasound imaging and hear the auscultation of the fetal heart tone if the fetal heart tone is audible.
- (3) At least eighteen (18) hours before the abortion, I was orally informed of the following:
 - a. That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care from the county office of family and children.
 - b. That the father of the unborn fetus is legally required to assist in the support of the child.
 - c. That adoption alternatives are available and adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.

I certify that the above information was received by me at least eighteen (18) hours prior to the date and hour scheduled for my abortion. I fully understand the full nature and extent of this consent and I therefore affix my name this _____ day of _____ 20____, in _____ Indiana, at _____:_____ a.m./p.m.

Signature of Patient

Signature of parent/legal guardian
(If patient is under 18)

Printed name of patient

Printed name of parent/legal guardian



Your Appointment is:

Date: _____ Time: _____

Surgery Appointment Information

You will be asked to fill out a medical chart including your medical history. You will meet with a counselor regarding your medical history, the abortion procedure, and post-operative care. You will have the opportunity to ask questions.

The duration of the pregnancy is based on weeks from the first day of your last menstrual period. The decision on pregnancy duration comes from ultrasound examination and the doctor's judgment.

Prior to the procedure, the doctor will review your medical history. If you have any additional questions or information about your past or present health, you may discuss these with him.

SUCTION CURETTAGE ABORTION

The doctor will perform a pelvic examination to determine the size and location of your uterus. Following the pelvic examination, the doctor will insert a speculum into your vagina. The speculum opens the vagina and allows the doctor to view the cervix, which is the opening into the uterus. He will cleanse the vagina and cervix with Betadine. Lidocaine, a local anesthetic, will be injected into the cervix. This medication will numb the cervix. He then dilates (opens) the cervix gradually using different size dilating rods until the cervix is open to the size of one finger. You will experience cramps that last about two to three seconds each while this is being done. This takes about thirty seconds to accomplish. The vacurette, or aspirator, is inserted through the cervix; and the suction machine is turned on. Suction is used to remove the pregnancy from the uterus. You will feel some pressure while this is being done and will experience some cramping, which is caused by the contraction of the uterus to control your bleeding. A curette, a small spoon-shaped instrument, is used to check the uterus to be sure all the tissue has been removed. **The entire procedure usually takes about three to five minutes.**

When the procedure is over, the nurse will help you dress and take you into the recovery room. We will check your bleeding and give you post-operative instructions. After about 30 minutes, you can leave and resume normal activities.

NOTICE: YOU MAY ENCOUNTER PROTESTORS AGAINST ABORTION ON THE STREET IN FRONT OF THE CLINIC. WE SUGGEST THAT YOU DO NOT STOP YOUR CAR, ROLL DOWN YOUR WINDOWS, OR EVEN TALK TO THESE PEOPLE. PULL DIRECTLY INTO THE PARKING LOT AREA, WHICH IS PRIVATE PROPERTY. PARK YOUR VEHICLE AND COME INTO THE CLINIC. THE ENTRANCE IS ON THE SIDE OF THE BUILDING; IT WILL SAY "CLINIC ENTRANCE" ON THE DOOR.

You also may want to call the clinic ahead, to see if we are open due to bad weather.

PREPARATION

- **Plan to be here between two to four hours.**
- Eat a light breakfast the morning of your appointment.
- **No alcohol or drugs twenty-four (24) hours before your appointment.**
- Please take a bath or shower the morning of your appointment.
- Please bring a clean pair of underpants and two maxi-pads with you.
- If you are taking medication, contact us for instructions.
- You may bring one person with you.
- **Please, NO children, toddlers, or infants.**

FEES AND PAYMENT

Fees are payable via **CASH or CREDIT CARD ONLY. NO PERSONAL CHECKS, MONEY ORDERS, OR CASHIER CHECKS.** All fees are due the day of the appointment, before you see the doctor. We do not accept insurance.

INDIANA STATE LAW INFORMATION, ULTRASOUND, RH FACTOR.....	\$ 100.00
<small>(This fee is REQUIRED AND NON-REFUNDABLE)</small>	
PROCEDURE (6 WEEKS TO 11 WEEKS 6 DAYS)	\$ 370.00
NITROUS OXIDE GAS	\$ 25.00
PRE-OPERATIVE ORAL MEDICATION (THIS IS AN OPTIONAL SERVICE) ...	\$ 25.00
IMMUNE GLOBULIN (NECESSARY, IF YOU HAVE RH NEGATIVE BLOOD) ..	\$ 40.00
POST-OPERATIVE PRESCRIPTIONS	\$ 30.00
FACILITY FEE	\$ 100.00
<small>(ONLY IF THE PROCEDURE IS NOT DONE FOR ANY REASON)</small>	

Nitrous Oxide Gas – Nitrous Oxide Gas reduces your cramping during the procedure. The gas does **not** put you to sleep. It makes you feel light-headed, tingly, and very relaxed. It takes effect in 60 to 90 seconds and leaves your body completely without side effects, in five (5) minutes.

Pre-Operative Oral Medication – Please call the clinic about this service. You must have a driver with you for the appointment. The driver will be required to sign a driver's consent form stating that they are driving you home, before you receive this medication.

Rh Negative Blood-Immune Globulin – (Rhogam) This medication is necessary if your blood type is Rh Negative.

Post-Operative Prescriptions – You will be given two prescriptions after surgery.

Weight – If you are overweight, the doctor may not be able to do the procedure. Please contact the clinic with any questions.

Identification – **INDIANA LAW REQUIRES THAT YOU MUST BRING IDENTIFICATION TO PROVE YOUR AGE, REGARDLESS OF YOUR AGE! A BIRTH CERTIFICATE (REQUIRED FOR PATIENTS UNDER 18), DRIVER'S LICENSE, I.D. CARD, OR OTHER LEGAL DOCUMENT. PATIENTS UNDER EIGHTEEN (18) MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN.** The parent or legal guardian will be required to sign consent forms and show identification. *If the last names are different, it will be necessary for the parent or guardian to bring identification proving that he or she is the parent or guardian.* If you have any questions concerning what kind of identification is necessary, please call the clinic and we will try to help you.

RISKS AND COMPLICATIONS

Abortion is a form of a minor surgery, which like all surgery has certain risks. Medicine and surgery are not exact sciences. Complications, both major and minor, can occur in a small percentage of cases, regardless of anyone's fault.

YOU ARE ASKED TO SIGN THIS STATEMENT INDICATING THAT YOU UNDERSTAND THE RISKS AND POSSIBLE COMPLICATIONS BEFORE YOU HAVE AN ABORTION PROCEDURE PERFORMED.

1. **PERFORATION OF THE UTERUS:** In a small number of cases, an instrument can puncture the wall of the uterus. Hospitalization may or may not be necessary then, depending on the extent of the injury. In a rare instance, there can be injury to the bowel or sufficient injury to the uterus that a hysterectomy is necessary. Blood transfusions may be prescribed, and there is additional health risks associated with blood transfusions. You should also know that if you have previously had a Cesarean Section there is some additional risk of perforation.
2. **INFECTION:** Minor and possible major infections can occur following an abortion. This occurs in a small percentage of cases. This can require antibiotic therapy.
3. **BLEEDING OR HEMORRHAGE:** Heavy bleeding immediately or shortly after an abortion may happen in a very small number of cases. This requires re-evaluation and possible hospitalization. The treatment would depend upon the cause of bleeding.
4. **ADVERSE REACTION TO ANESTHETIC:** In a small number of cases, local anesthetics cause extremely severe reactions, including rare instances of convulsions, cardiac arrest, prolonged unconsciousness, shock, or even death. Severe complications from the use of local anesthetics are extremely rare.
5. **MISSING ALL OR PART OF THE PREGNANCY:** In approximately 6 out of 1,000 procedures, some of the pregnancy is missed. It may not be obvious to the doctor at the time the procedure is performed, but it can be determined by a laboratory examination of the removed tissue. Bleeding and/or infection can result. If all tissue is not removed, the procedure which you are authorizing will be repeated at no charge if you provide a post-operative examination report dated within one (1) month thereof confirming continuation of pregnancy or presence of tissue and showing when and by whom the examination was performed. In a very small percentage of cases, a woman may have a continuing pregnancy due to multiple pregnancies, a double uterus, or a pregnancy in the tubes (ectopic pregnancy). A tubal, or ectopic, pregnancy is difficult to detect and will usually require hospitalization and surgery.

I HAVE READ (OR HAD READ TO ME) THE ABOVE RISKS AND COMPLICATIONS.

SIGNATURE OF PATIENT _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____

DATE _____ WITNESS _____

EXPLANATION AND WRITTEN CONSENT FOR ABORTION

I hereby request and consent to submit to the following medical procedure to be performed by

Dr. _____, in the Affiliated Women's Services, Inc. Clinic.

I, _____, am _____ years of age and was born on

_____, 19_____. I am choosing to have an abortion procedure performed on me using the Suction Curettage method, which has been fully described to me as well as having been provided with a written explanation and video on "First Trimester Abortion" to be seen in the clinic. I have been informed of the medical risks in the abortion procedure to be utilized. I have also been advised that:

1. There may be detrimental physical and psychological effects from abortion that are not foreseeable.
2. There are alternatives to abortion, including childbirth and adoption.
3. There may be a period of time during which I may be incapacitated.

I consent to the use of anesthetics, medications, ultrasound examination, and any other treatment as ordered by

the physician. My last menstrual period started on _____. I consent to my physician or his medical assistants giving me painkillers, including Nitrous Oxide gas. **I also understand that any medical care which may be required, other than the procedure itself or a repetition of the procedure, is my own responsibility.** I further understand that if a major complication arises, I may have to be hospitalized and may require minor or major surgery to protect my health. Blood transfusions may be necessary during treatment and I am aware that there are other health risks associated with blood transfusions, but I consent to any such emergency treatment that the physician deems appropriate. I agree to cooperate with the physician and his medical assistants during the procedure. I understand that my cooperation is crucial for the procedure to be safely accomplished. I agree to make no claims against the physician or clinic for complications, which may occur, except in the event of gross negligence on their part. If I should make any other claims, I agree to be responsible for the payment of the costs of attorney's fees incurred by the physician and/or clinic in investigation or defending the claims, and to post a bond in advance for such sums. In the event that A.W.S., Inc. or its agent requires my medical records, past or future, I direct any hospital, physician, or health facility to release said records.

I certify that I have read (or had read to me) this EXPLANATION AND WRITTEN CONSENT FOR ABORTION.

SIGNATURE OF PATIENT _____

I, THE UNDERSIGNED, CERTIFY that I am the PARENT OR LEGALLY APPOINTED GUARDIAN for the above named patient. I further certify that I have read (or had read to me) the above consent and reference forms. I understand that I have the same rights to ask questions and will view the video on "First Trimester Abortion" at the clinic. I have the right to refuse my consent as outlined for the above patient. I hereby give my daughter consent and authorize the above physician to perform an ABORTION ON:

Name of Patient: _____

Signature of Parent or Legal Guardian: _____



AFFILIATED WOMEN'S SERVICES, INC.

2215 DISTRIBUTORS DRIVE
INDIANAPOLIS, IN
(800) 692-3424 (317) 241-0215

How to Find Us

From I-465 NORTH of Indianapolis – Take I-465 to the INDIANAPOLIS AIRPORT EXIT. This EXIT has two (2) lanes. Take the LEFT lane to the SAM JONES EXPRESSWAY. When you are on the SAM JONES EPXRESSWAY, you will see the ADAMS MARK HOTEL on your RIGHT. You will see an exit marked EXECUTIVE DRIVE. Take this exit onto EXECUTIVE DRIVE.

FOLLOW EXECUTIVE DRIVE NORTH TO THE SECOND FOUR WAY STOP SIGN, WHICH IS RAYMOND STREET. TURN TO YOUR LEFT ONTO RAYMOND STREET AND GO TWO (2) BLOCKS TO DISTRIBUTORS DRIVE. WE ARE LOCATED ON THE SOUTHEAST (LEFT) CORNER OF DISTRIBUTORS DRIVE AND RAYMOND STREET. THE ADDRESS IS 2215 AND IS MAKRED ON THE OUTSIDE OF THE BUILDING. DRIVE DIRECTLY INTO THE PARKING LOT ON THE SOUTH SIDE OF THE BUILDING. USE THE SIDE ENTRANCE TO ENTER THE RECEPTION ROOM.

From I-465 SOUTH of Indianapolis – Take I-465 to the SAM JONES EXPRESSWAY. Take the EXIT RIGHT onto the SAM JONES EXPRESSWAY. Then take the first EXIT RIGHT off the SAM JONES EXPRESSWAY, which is marked EXECUTIVE DRIVE, TURN RIGHT ONTO EXECUTIVE DRIVE. Once you are on EXECUTIVE DRIVE **FOLLOW THE UNDERLINED INSTRUCTIONS ABOVE!**

From I-70 EAST of Indianapolis – Take I-70 West to the SAM JONES EPXRESSWAY EXIT. There is one lane. Once you are on the SAM JONES EXPRESSWAY, take the SECOND EXIT RIGHT, which is marked EXECUTIVE DRIVE. Turn left onto EXECUTIVE DRIVE. Once you are on EXECUTIVE DRIVE **FOLLOW THE UNDERLINED INSTRUCTIONS ABOVE!**

From I-70 WEST of Indianapolis – Take I-70 East to I-465 NORTH to the SAM JONES EXPRESSWAY. Take the first EXIT RIGHT off the SAM JONES EPXRESSWAY onto EXECUTIVE DRIVE. Once you are on EXECUTIVE DRIVE **FOLLOW THE UNDERLINED INSTRUCTIONS ABOVE!**

NOTICE: You may encounter protestors against abortion on the street in front of the clinic. We suggest that you do not stop your car, roll down your windows, or even talk to them! DRIVE DIRECTLY INTO THE PARKING AREA, WHICH IS PRIVATE PROPERTY, PARK YOUR VEHICLE AND COME INTO THE CLINIC. The ENTRANCE is marked on the side of the building.

LOOK FOR THE SIGN AWSTHAT'S US!!!

*****SEE MAP ON BACK OF PAGE*****

