Statement of Informed Consent
Medical Abortion

Name:
Date of Birth:
Address:

PLEASE READ CAREFULLY BEFORE SIGNING:

I have been fully informed of, and understand to my complete satisfaction:

- ☐ the medications involved in a medical abortion, how they work to complete an abortion, and how they should be taken;
- ☐ side effects associated with a medical abortion;
- ☐ potential risks and complications associated with a medical abortion, some of which may require further treatment;
- ☐ if my abortion fails and I have an ongoing pregnancy that goes beyond 12 weeks of pregnancy, it is illegal for a doctor to provide an abortion unless there is a risk to life or health, risk to life or health in an emergency or condition likely to lead to death of foetus;
- ☐ if my blood type is rhesus negative and I am over 7 weeks pregnant, an injection of anti-D is part of my abortion care;
- ☐ it is necessary to confirm that the abortion was successful in ending the pregnancy by taking a specific low sensitivity pregnancy test provided to me by my doctor, approximately two weeks after my abortion is complete;
- ☐ pregnancy tissues will be disposed of as per hospital policy (appropriate for medical abortions within the hospital setting).

Patient Statement

The booklet 'Your Guide to Medical Abortion' was provided to me. I have read and understood all information that has been presented to me in this booklet and by my doctor. I have had the opportunity to ask questions about this information. I consent to a medical abortion of my own freewill.

Patient Name: **Signature:** **Date:**	**Parent/Guardian Name:** **(if required)** **Signature:** **Date:**

Medical Practitioner Statement

I confirm that in my opinion, the patient understands the nature of the treatment. I have provided them with the 'Your Guide to Medical Abortion' booklet and explained what the treatment will involve, the benefits and risks of this and any alternative treatments
I discussed any particular concerns of this patient. These were explained to my patient in terms suited to their understanding and they are able to give informed consent.

Medical Practitioner Name:
Medical Council Registration Number:
Signature:
Date:

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