Statement of Informed Consent
Surgical Abortion

Name:
Date of Birth:
Address:

PLEASE READ CAREFULLY BEFORE SIGNING:

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

- ☐ the nature, consequences and side effects associated with a surgical abortion;
- ☐ potential risks and complications associated with a surgical abortion, some of which may require further treatment;
- ☐ information in relation to the disposal of pregnancy tissue;
- ☐ 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 is complete 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.

Patient Statement

The 'Your Guide to Surgical Abortion' booklet 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 surgical 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 Surgical Abortion' booklet and have explained what the treatment will involve, the benefits and risks of this and any alternative treatments I have 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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