

**Medical Abortion Post Operative Instructions**  
Potomac Family Planning Center  
Jackson Place North 966 Hungerford Drive Suite 24 Rockville, MD 20850

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In case of an emergency please call:

- During normal business hours..... (800) 260-2464
- After hours (Medical Bureau will page the doctor)..... (800) 301-2615
- To page the doctor directly..... (202) 592-0139

**IMPORTANT THINGS TO KNOW:**

1. Bleeding *MAY* begin after taking Mifeprex in our office.
2. When you use Misoprostol suppositories at home you will experience bleeding, heavier than a normal period. Have someone with you.
3. You may experience cramping which will become most intense during expulsion, commonly a 1-3 hour period. Afterwards the pain usually subsides. You may expect bleeding or spotting for an average of 9-16 days.
4. It is not uncommon to have a headache, feel nauseous, vomit or have diarrhea.
5. For 14 days you should not have intercourse, use tampons, take baths, douche, swim or engage in strenuous activity. You may take showers.
6. Take your temperature each morning and evening for the next five days. If it is 100.4 degrees for more than four hours, contact the center immediately.
7. Take all prescribed medication as directed by the physician.
8. Do not drink alcoholic beverages of any type.

**IF YOU EXPERIENCE ANY OF THE FOLLOWING CALL:**

- Temperature above 100.0 degrees for more than four hours soon after using misoprostol.
- Soaking 2 sanitary pads per hour for 2 consecutive hours.
- Bleeding heavily for more than 12 hours in a row.
- Passing clots larger than lemons.
- **NO** bleeding within 24 hours after using misoprostol.
- Allergic reaction to any medication (itching, rash or hives).
- Severe pain **not** relieved by pain medication.
- Foul odor after inserting vaginal suppositories

\_\_\_\_\_ will be with me when I use the misoprostol.

My follow up appointment is scheduled for \_\_\_\_\_. If I am unable to make it to my follow I will call the center to re-schedule.

I may be reached at this number: \_\_\_\_\_.

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE