POTOMAC FAMILY PLANNING CENTER

Voluntary Informed Consent for Medical Abortion with Mifepristone and Misoprostol

I, ____________________, age _____, hereby give my consent to and request and authorize Earl N. McLeod, M.D., or a physician designated by he/she, together with any necessary assistants, to perform upon me, a MEDICAL ABORTION by use of Mifeprex 200mg and misoprostol 800mcg. I have been informed of other options during early pregnancy including continuing the pregnancy and becoming a parent, continuing the pregnancy and making adoption arrangements, and surgical abortion. I have been informed of the risks involved with a surgical abortion and a medical abortion, and the risks involved with continuing the pregnancy. I acknowledge no guarantee or assurance has been made to me concerning the medical abortion procedure.

The nature of pregnancy, the nature and purpose of an abortion, the probability of success of such a method, the possible physical and psychological effects which might be unforeseeable, the risks involved, and the possibility of complications including but not limited to *pain and suffering, emotional upset, retained products of conception, bleeding and infection of varying degrees, ruptured ectopic pregnancy, adverse reaction to medications, heart attack, and (in rare instances) death, have been fully and reasonably explained to me. I understand the incidence of fatal toxic shock following medical abortion is approximately 1 in 125,000.* I have fully disclose my medical history including the date of my last menstrual period, allergies, blood conditions, prior medications or drugs, and reactions to medications or drugs. I certify that I have read this form or it has been read to me. I understand its contents and have been given an opportunity to ask questions. All my questions were answered to my satisfaction. I further certify that I have been given the Mifeprex Medication Guide, and that I had an opportunity to read it and discuss it with my provider.

I understand women cope differently with emotional distress associated with abortion and often go through the process with minimal effect. I understand emotional distress is a potential complication of abortion and release the clinic, the attending physicians, staff and assistants from any liability, or responsibility for any conditions including but not limited to short or long term psychological effects resulting from my decision to have an elective abortion. I understand that I will be given Mifeprex based on an evidence-based regimen. **Rather than the FDA approved regimen of 600mg Mifeprex and 400mcg of oral Misoprostol, I will be given a 200mg dose of Mifeprex in the office. I will be given an 800mcg dose of vaginal or buccal Misoprostol to be taken at home.** Research shows that this off label use is a safe and effective alternative regimen and causes less stomach upset.

I understand that Mifeprex (Mifepristone) and Misoprostol can cause birth defects, and if the medical abortion is not complete, I agree to have a surgical abortion. Should hospitalization for any reason be necessary, I understand neither the physician, employees, clinic nor corporation will be responsible for any costs incurred. I acknowledge that I have read and understand the FDA approved regimen as outlined in

the Mifeprex Medication Guide and Patient Agreement, I have signed the Patient Agreement, and understand the reason(s) why the FDA approved regimen is being altered. I further acknowledge that I have been given the opportunity to ask questions about the alternative evidence-based regimen and all my questions have been answered to my satisfaction. I understand that this consent form amends the signed Patient Agreement.

I certify that I fully understand the above consent to the medial abortion and the nature of the procedure, risks, benefits and alternatives therein referred were fully explained to me and all my questions have been answered to my satisfaction. I have as a result, been able to make an informed intelligent and voluntary choice about undergoing a medical abortion. I certify this consent was made without coercion, duress or haste, while I was of sound mind and under no sedation whatsoever.

______________________________	____________________	______
Patient's Signature	Date	Time

____
Patient's Name Printed

______________________________	____________________	______
Witness Signature	Date	Time