NOTICE TO ALL PATIENTS

Alabama law provides that abortions may be performed only with the voluntary and informed consent of the patient. This form (front and back) is important to ensure that you have been provided all the information you need to make a fully informed decision. Please complete the form truthfully and accurately.

CERTIFICATION OF RECEIPT OF ABORTION INFORMATION

I certify that I have received the printed materials entitled "Did You Know" and "Alabama's Resource Directory For Women, Children and Families"

by mail on _____ and again in person on _____.
(date) (date)

OR

only in person on _____.
(date)

I understand that Alabama law requires that I be provided these materials at least 24 hours before I undergo an abortion, and I certify that this requirement of the law has been met for me.

_____ _____
Signature of Patient Date

CERTIFICATION OF OPPORTUNITY TO VIEW ULTRASOUND

I certify that Dr._____, who is the referring physician or the physician who is to perform the abortion, has performed an ultrasound of my unborn child. I certify that I have been offered the opportunity to see this ultrasound and (check only one):

____ I have reviewed the ultrasound before the abortion.

OR

____ I rejected the opportunity to view the ultrasound before the abortion.

_____ _____
Signature of Patient Date

CERTIFICATION OF VOLUNTARY AND INFORMED CONSENT FOR ABORTION

On _____, I was informed in person by _____ of
(date) (name of physician or other qualified person)
the following (check all that apply):

____ The abortion will be performed by _____.
(physician's name)

____ The details of the medical or surgical method to be used in performing the abortion, and the medical risks associated with this particular procedure.

____ That I have the right to view an ultrasound of my unborn child, as well as a video entitled "Did You Know," and I have been offered the opportunity to view both.

____ Whether there is a need for me to receive anti-Rh immune globulin therapy, the cost of such therapy, and if I am Rh negative, the likely consequences of refusing such therapy.

____ That I cannot be forced or required by anyone to have an abortion, and that I am free to withhold or withdraw my consent to abortion without affecting my right to any future care or treatment, and without the loss of any state or federally funded benefits to which I might otherwise be entitled.

____ The probable gestational age of my unborn child and the probable anatomical and physiological characteristics of my unborn child as of the date the abortion is to be performed. I have also been advised that (check only one):

____ My unborn child has a gestational age of more than 19 weeks or is viable and that: 1) my child may be able to survive outside the womb; 2) I have the right to request that the physician use the method of abortion that is most likely to preserve the life of my unborn child, provided that method is not prohibited by law; and 3) if my unborn child is born alive, the physician has the legal obligation to take all reasonable steps necessary to maintain the life and health of the child.

OR

____ My unborn child has a gestational age of 19 weeks or less, or an ultrasound has been performed and the physician's good faith clinical judgment is that my unborn child is not viable.

I certify and affirm that I have received the above information, that I have had the opportunity to consider the alternatives available to me, and that I do hereby voluntarily give my fully informed consent to the abortion of my unborn child.

_____ _____
Signature of Patient Date

MEDICAL EMERGENCY ABORTION FORM

Sections 1 and 2 must be completed by the physician performing the medical emergency abortion.

1. It is my good faith clinical judgment that a medical emergency exists that so complicates the medical condition of _____, the patient and a pregnant woman, that an immediate abortion of her pregnancy is necessary. To delay performing this emergency abortion by obtaining informed consent, as otherwise required, would create a serious risk of substantial and irreversible impairment of a major bodily function, or could result in her death. The medical condition(s) that establish this as an emergency is:

_____

_____

_____

_____

_____ _____
Physician MD/DO Date

2. Complete 2A or 2B

A. The patient, _____, was informed prior to the abortion, of the medical conditions which necessitate the performance of an emergency abortion.

_____ _____
Physician MD/DO Date

B. The patient, _____, was not informed prior to the abortion of the medical conditions which necessitate the performance of the emergency abortion, due to the urgency of the situation and the severity of her condition.

_____ _____
Physician MD/DO Date