



Consent form – Voluntary pregnancy termination by surgical procedure

I understand that the purpose of this procedure is to terminate my pregnancy. The method was explained to me.

I hereby authorize Dr. _____ (or the doctor on duty) to perform an abortion on me. Furthermore, I authorize said doctor to dispose of the removed tissue according to the medical practice norms.

I understand that a voluntary termination of pregnancy carries some degree of risk, and that complications, although very rare, may happen despite the best intentions and skills of the doctor. I was informed that there is a possibility of infection, retention, hemorrhage, damage to the cervix or to the uterus, as well as allergic reaction. Furthermore, there is a very remote possibility of error in the estimation of the age of the pregnancy and of its location. I may have to come back to the Clinic to do a blood test and/or a follow up ultrasound to ensure the procedure is complete, especially for pregnancies of less than 6 weeks of age. An abortion, provided under safe conditions by a trained physician, includes a minimal risk of death. I have been informed of all these risks for my safety and for legal reasons.

I was informed that the procedure will be performed using intravenous sedation and analgesia as well as a local anesthetic. This medication will temporarily decrease my level of consciousness and will cause drowsiness. There is a risk of allergic reaction and respiratory depression (decrease of the respiratory rate), for which I will constantly be evaluated by the doctor and the nurse until I return to my initial level of consciousness. I authorize any treatment or unplanned intervention which might become necessary and for which it would be impossible to obtain my consent. **I was informed that I should not drive nor sign important documents in the 24 hours following the procedure.**

I authorize la Clinique des femmes de l'Outaouais to send my personal information and other information relevant to this pregnancy to the Gatineau hospital, in the event that I should be transferred to their care quickly or if the termination of pregnancy cannot take place at the Clinic.

I certify that I have received the document entitled "Information Guide – Voluntary Termination of Pregnancy", in its version 04-18. This guide presents all the information needed to get ready for the intervention and to facilitate a good recovery.

I have read and understood the above consent form and have had the opportunity to discuss any concerns or questions that I might have concerning this abortion.

And I sign.

Signature _____ Date: _____

Witness: _____

Consent validated by the doctor in charge of the anesthetics and the pregnancy termination

Doctor's signature

Date