Consent Form Sample

Patient Acknowledgement of Physician Counseling
(Tennessee Code Annotated, Sections 39-15-202 and 39-15-219(m)(1)(A) and (B))

Name: _____ Patient ID Number: _____ Date of Birth: _____

I acknowledge that I was provided the following information by Dr._____.

Date and Time of Physician Counseling:

_____

- Confirmation that I am pregnant.
- The probable gestational age of the pregnancy at the time the abortion is to be performed based upon my ultrasound.
- The following statement: If 24 or more weeks have elapsed from the first day of a woman's last period or 22 or more weeks have elapsed from the time of conception, a woman's unborn child may be capable of survival outside the womb, with or without medical assistance. If a viable child is born prematurely in the course of an abortion, a physician must take steps to preserve the health and life of the child.
- The following statement: Numerous public and private agencies and services are available to assist a woman during pregnancy and after the birth of her child whether she keeps the child or places it for adoption. If you choose not to have the abortion, [provider] can provide a list of the agencies and the services available to you.
- The normal and reasonably forseeable medical benefits and risks of undergoing an abortion or continuing the pregnancy to term.

At least forty-eight (48) hours have elapsed since I received this counseling, and I consent to an abortion procedure.

<u>For in-clinic abortion:</u>

Tennessee law provides that in-clinic abortion patients have the right to determine whether the final disposition of the fetal remains is by cremation or interment, and the location.

[Provider] is required to arrange for cremation or interment of the fetal remains from the in-clinic abortions provided at our health centers. We have arranged for [insert service: cremation and/or interment] at [insert location].[1] You may select a different method and/or location, but you will be responsible for making those arrangements and for any associated costs. If you do not select a different method and/or location, we will proceed with the arrangements described above.

[1] If unforeseen circumstances beyond our control preclude us from arranging for [insert service] at [insert location], [Provider] will arrange for comparable services for final disposition. Any changes will be noted in health center and patient records and can be shared upon request for the duration of time that the health center is required to maintain these records.

Select one option:

- ❑ I would like the health center to arrange for the final disposition of the fetal remains by [cremation or interment] at [location], as is the standard practice at this health center.
- ❑ I will make my own arrangements for final disposition by cremation or interment (please circle one) at a different location at my own expense.

If you selected to make your own arrangements, please provide the name of the funeral home or crematory and address: _____
_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Parent/Guardian/Custodian Signature: _____ Date: _____
(when required)