



ABORTION INFORMED CONSENT CERTIFICATION

State Form 55320 (R6 / 8-24)

INDIANA DEPARTMENT OF HEALTH – IC 16-34-2-1.1(a)

PURPOSE OF FORM: This form documents your voluntary and informed consent to an abortion at least eighteen (18) hours before the abortion, except in the case of a medical emergency. In this form, “abortion” refers to either a surgical abortion or a medication abortion (abortion resulting from an abortion inducing drug). The completed form is kept by the provider as part of your medical record. You will be provided with a copy of the completed form.



Patient Certification of Informed Consent

I certify and affirm that:

1. The physician who is to perform the abortion, the referring physician or a physician assistant (as defined in IC 25-27.5-2-10), an advanced practice nurse (as defined in IC 25-23-1-1(b)), or a midwife (as defined in IC 34-18-2-19) to whom the responsibility has been delegated by the physician who is to perform the abortion or the referring physician has, in private and not a group, at least eighteen (18) hours before the abortion is performed, informed me orally and in writing of the following:
 - A. The name of the physician performing the abortion, the physician's medical license number, and an emergency telephone number where the physician or the physician's designee may be contacted on a twenty-four (24) hour a day, seven (7) day a week basis.
 - B. That follow-up care by the physician or the physician's designee (if the designee is licensed under IC 25-22.5) is available on an appropriate and timely basis when clinically necessary.
 - C. The nature of the proposed procedure or information concerning the abortion inducing drug.
 - D. Objective scientific information of the risks of and alternatives to the procedure or the use of an abortion inducing drug, including:
 - (1) the risk of infection and hemorrhage;
 - (2) the potential danger to a subsequent pregnancy; and
 - (3) the potential danger of infertility.
 - E. That human physical life begins when a human ovum is fertilized by a human sperm.
 - F. The probable gestational age of the fetus at the time the abortion is to be performed, including:
 - (1) a picture of a fetus;
 - (2) the dimensions of a fetus; and
 - (3) relevant information on the potential survival of an unborn fetus; at this stage of development.
 - G. That objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age.
 - H. The medical risks associated with carrying the fetus to term.
 - I. The availability of fetal ultrasound imaging and auscultation of fetal heart tone services to enable the pregnant woman to view the image and hear the heartbeat of the fetus and how to obtain access to these services.
 - J. The pregnancy of a child less than fifteen (15) years of age may constitute child abuse under Indiana law if the act included an adult and must be reported to the department of child services or the local law enforcement agency under IC 31-33-5.
 - K. That Indiana does not allow a fetus to be aborted solely because of the fetus's race, color, national origin, ancestry, sex, or diagnosis or potential diagnosis of the fetus having Down syndrome or any other disability.
 - L. That no one has the right to coerce the pregnant women to have an abortion.

Patient MRN: _____

2. I have been informed orally and in writing of the following:
 - A. That medical assistance benefits may be available for prenatal care, childbirth, and neonatal care from the county office of the Division of Family Resources.
 - B. That the father of the unborn fetus is legally required to assist in the support of the child. In the case of rape, the information required under this clause may be omitted.
 - C. That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.
 - D. That there are physical risks to the pregnant woman in having an abortion, both during the abortion procedure and after.
 - E. That Indiana has enacted the safe haven law under IC 31-34-2.5.
 - F. That the pregnant woman has a right to determine the final disposition of the remains of the aborted fetus, and information concerning the available options for disposition of the aborted fetus.
 - G. Information concerning any counseling that is available to a pregnant woman after having an abortion.

3. I have been provided a color copy of the IDOH Informed Consent Brochure (image to the right is of the brochure) and been informed that the IDOH Informed Consent Brochure is posted on the IDOH Web site. The internet web site address of the Indiana Department of Health's web site is <https://www.in.gov/health/>. The direct link to the IDOH Terminated Pregnancy (Abortion) Information is <https://www.in.gov/health/cshcr/acute-and-continuing-care/abortion-information-center/>



The IDOH Informed Consent Brochure includes the following information:

- A. Objective scientific information concerning the probable anatomical and physiological characteristics of a fetus every two (2) weeks of gestational age, including the following:
 - (1) Realistic pictures in color for each age of the fetus, including the dimensions of the fetus.
 - (2) Whether there is any possibility of the fetus surviving outside the womb.
 - B. Objective scientific information concerning the medical risks associated with each abortion procedure and abortion inducing drug, including the following:
 - (1) The risks of infection and hemorrhaging.
 - (2) The potential danger:
 - (i) to a subsequent pregnancy; or
 - (ii) of infertility.
 - C. Information concerning the medical risks associated with carrying the child to term.
 - D. Information that medical assistance benefits may be available for prenatal care, childbirth, and neonatal care.
 - E. Information that the biological father is liable for assistance in support of the child, regardless of whether the biological father has offered to pay for an abortion.
 - F. Information regarding telephone 211 dialing code services for accessing human services as described in IC 8-1-19.5, and the types of services that are available through this service.
4. This form is being completed at least eighteen (18) hours before the abortion, except in the case of a medical emergency.
 5. I am not being coerced to have an abortion and I voluntarily consent to the abortion.

Patient MRN: _____

6. I certify the following: (*Select appropriate item*)

_____ I am eighteen (18) years of age or older. (*Attach documentation of age*)

_____ I am under eighteen (18) years of age but have been emancipated by a court order or issued a waiver of parental consent by a juvenile court. (*Attach copy of court order or waiver*)

_____ I am under eighteen (18) years of age (*Parent or guardian consent required; see following section.*)

Printed Name of Patient

Patient's Medical Record Number

Signature of Patient

Date (*month, day, year*)

Time

Parent / Guardian Certification and Notarization (if required)

IC 16-18-2-267

IC 16-34-2-4

The consent of a parent or guardian is required if a woman having the abortion is under the age of eighteen (18) unless the woman has been emancipated by a court order or issued a waiver of parental consent by a juvenile court.

I certify that:

1. I am the parent or legal guardian of the patient identified above. (*Attach documentation of parental or guardian status.*)
2. My child or ward, in private and not a group, has been provided the information listed in paragraph 1 above orally and in writing.
3. My child or ward has been provided the information listed in paragraphs 2 and 3 above orally and in writing.
4. This form is being completed at least eighteen (18) hours before the abortion, except in the case of a medical emergency.
5. My child or ward voluntarily consents to having the abortion.
6. I voluntarily consent to my child or ward having the abortion.

Printed Name of Parent / Guardian

Relationship to Patient

Signature of Parent Guardian

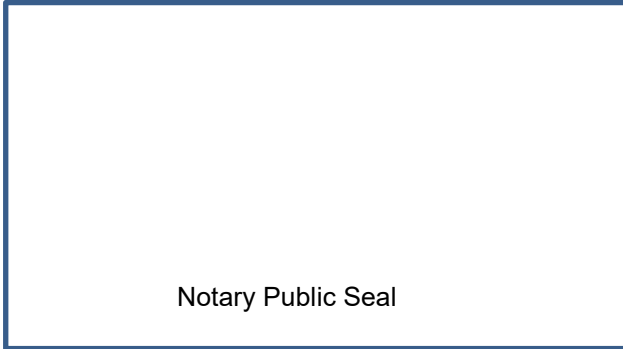
Date (*month, day, year*)

Time

Patient MRN: _____

State of Indiana
County of: _____

Having personally appeared and upon positive identification; signed and affirmed under oath before me on _____, 20__ by _____.



Notary Public Signature
Commissioned in _____ County.

Provider Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the information in paragraph 1 above was provided orally and in writing, in private and not a group, to the patient named above.
2. At least eighteen (18) hours before the abortion, the patient named above was verbally asked if she was being coerced to have an abortion.
3. At least eighteen (18) hours before the abortion, the information listed in paragraphs 2 and 3 above was provided orally and in writing to the patient named above.
4. The patient has voluntarily and without coercion consented to the abortion as reflected above.
5. If applicable, the patient's parent or guardian has voluntarily consented to the abortion as reflected above.
6. A completed copy of this form has been provided to the patient and, if applicable, the patient's parent or guardian.

Printed Name of Physician or Other Provider

Professional Credentials

License Number

Signature of Physician or Other Provider

Date (*month, day, year*)

Patient MRN: _____