



**CERTIFICATION OF PROVISION OF PERINATAL HOSPICE INFORMATION  
(TIME OF ABORTION CONSENT DECISION)**

State Form 56108 (R / 8-24)

INDIANA DEPARTMENT OF HEALTH – IC 16-25-4.5-4, IC 16-34-2-1.1(b)(c)

PHYSICIAN RESPONSIBLE FOR COMPLETION OF FORM: A physician who performs an abortion for a pregnant woman whose unborn child has been diagnosed with a lethal fetal anomaly is responsible for providing this form to the patient, securing the patient's certification, and certifying the form at least eighteen (18) hours before the abortion.

PURPOSE OF FORM: This form applies to you if your unborn child has been diagnosed with a lethal fetal anomaly. It documents that, at least eighteen (18) hours before the abortion:

- (1) The physician who will perform the abortion has informed you, orally and in person, of the availability of perinatal hospital services;
- (2) The physician who will perform the abortion has given you a printed copy of the IDOH Perinatal Hospice Brochure, and a printed list of perinatal providers and programs in Indiana, as required under IC 16-25-4.5-4 and IC 16-25-4.5-5; and
- (3) You choose to have an abortion rather than continuing your pregnancy with perinatal hospice care.

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**

I certify that:

1. I have been provided with the following information (*Please initial.*):  
 A copy of the IDOH Perinatal Hospice Brochure  
 A list of perinatal hospice providers and programs in Indiana
2. The information described above was provided to me at least eighteen (18) hours before the abortion by the physician who will perform the abortion.
3. I choose to have an abortion rather than continuing my pregnancy with perinatal hospice care.

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 (if required)**

The certification 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. The information described above was provided to my child or ward at least eighteen (18) hours before the abortion by the physician who will perform the abortion.
3. My child or ward chooses to have an abortion rather than continuing her pregnancy with perinatal hospice care.

\_\_\_\_\_  
Printed Name of Parent / Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date (month, day, year)

\_\_\_\_\_  
Time

**Physician Certification**

I certify that:

1. I am the physician who will perform the abortion for the patient identified above.
2. At least eighteen (18) hours before the abortion, I have provided all the required information described above.
3. I have had the patient and, if applicable, the patient's parent or guardian complete this form.
4. 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

\_\_\_\_\_  
Professional Credentials

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date (month, day, year)