Reset Form

AVAILABLE COUNSELING AFTER AN ABORTION

State Form 56115 (R / 8-24)
INDIANA DEPARTMENT OF HEALTH – IC 16-34-2-1.1(a)(2)(J)

PURPOSE OF FORM: This form documents that you are timely provided with information concerning any counseling that is available to you after having an abortion. At least eighteen (18) hours before the abortion, the provider must inform you orally and in writing of any counseling that is available to you after having an abortion. 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.

Counseling Information

Information concerning counseling that is available to a woman after having an abortion:

Real Alternatives *(unlicensed)*
Telephone: 1-888-LIFE AID
Website: www.realalternatives.org

Indiana 211 Partnership *(referral source)*
Telephone: 2-1-1 *(where supported)*
Website: www.in211.org

International Hotline for Abortion Recovery *(licensed and unlicensed)*
Telephone: 866-482-5433
Website: www.internationalhelpline.org

National Board for Certified Counselors *(counselor directory)*
Telephone: 336-547-0607
Website: www.nbcc.org/CounselorFind

The Indiana Professional Licensing Agency (317-232-2980, www.in.gov/pla) has listings and other information about licensed counselors in Indiana.

Patient Certification

I certify that:

1. I have been informed orally and in writing of the above information.
2. The above information was provided to me and this form is being completed at least eighteen (18) hours prior to the abortion.

I further 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 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 has been provided orally and in writing with information concerning any counseling that is available to her after having an abortion.

3. The above information has been provided to my child or ward at least eighteen (18) hours before the abortion.

_____ _____

Printed Name of Parent / Guardian Relationship to Patient

_____ _____ _____

Signature of Parent Guardian Date *(month, day, year)* Time

Provider Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the patient named above has been provided orally and in writing with information concerning any counseling that is available to her after having an abortion.

2. A completed copy of this form has been provided to the patient and, if applicable, to 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)*