**AVAILABLE COUNSELING AFTER AN ABORTION**

State Form 56115 (8-16)

Indiana State 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](http://www.realalternatives.org)

Indiana 211 Partnership *(referral source)*

Telephone: 2-1-1 *(where supported)*

Website: [www.in211.org](http://www.in211.org)

International Hotline for Abortion Recovery *(licensed and unlicensed)*

Telephone: 866-482-5433

Website: [www.internationalhelpline.org](http://www.internationalhelpline.org)

National Board for Certified Counselors *(counselor directory)*

Telephone: 336-547-0607

Website: [www.nbcc.org/CounselorFind](http://www.nbcc.org/CounselorFind)

*The Indiana Professional Licensing Agency (317-232-2980,* [*www.in.gov/pla*](http://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.)*

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Printed Name of Patient Patient’s Medical Record Number

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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.

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Printed Name of Parent / Guardian Relationship to Patient

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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.

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Printed Name of Physician or Other Provider Professional Credentials License Number

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Signature of Physician or Other Provider Date *(month, day, year)*