

ABORTION INFORMATION PROVISION CERTIFICATION

(Completion of this form by the patient is required under Wisconsin State Statute 253.10)

An exemption to the 24 hour wait period may be allowed if the pregnancy is the result of a sexual assault or incest or if there is a medical emergency.

_____ (name of physician) orally informed me, in person, on _____ (date) at _____ a.m./p.m. of the following:

That, according to my physician's reasonable medical judgment, I am pregnant and the probable gestational age of the fetus, on this date, is _____ weeks.

- 1. The probable anatomical and physiological characteristics of the fetus on this date.
- 2. That fetal ultrasound imaging and auscultation of fetal heart tone services are available that enable viewing the image or hearing the heartbeat of the fetus and how these services can be obtained.
- 3. The particular medical risks, if any, associated with my pregnancy.
- 4. The details of the medical or surgical method that would be used in performing or inducing an abortion.
- 5. The medical risks associated with the particular abortion procedure that would be used, including the risk of infection, psychological trauma, hemorrhage, endometritis, perforated uterus, incomplete abortion, failed abortion, or danger to subsequent pregnancies and infertility.
- 6. The recommended general medical instructions to follow after an abortion to enhance safe recovery and the name and telephone number of a physician to call if complications arise.

Physician's telephone number: _____

- 7. If, in the reasonable medical judgment of my physician, the fetus has reached viability, that the physician who is to perform or induce the abortion is required to take all steps necessary under law to preserve the life and health of the fetus.
- 8. That I have the right to withdraw consent, cancel the appointment or not show for the appointment at any time before the procedure is performed.
- 9. That no payment for the procedure may be required from me until at least 24 hours have elapsed after the informed consent consultation has been completed, except if the waiting period is shortened by me because the pregnancy is the result of sexual assault or incest.

I certify that this information was provided in an individual setting that protected my privacy, maintained the confidentiality of my decision and ensured that the information focused on my individual circumstances but that did not prevent me from having a person of my choice present. I certify that I was allowed adequate opportunity to ask questions and all my questions were answered in a satisfactory manner.

(patient)

(date)

(parent, guardian, legal custodian, adult family member, foster parent or treatment foster parent, if applicable for a minor)

(date)

(guardian of patient who has been adjudicated incompetent if applicable)

(date)

