DATE: _____ HOUR: _____

1. I authorize Dr. _____ and/or other authorized practitioner(s) and such assistants as may be selected by said physician(s), to perform an abortion on (Name of Patient) _____

   ABORTION. Abortion means the use or prescription of any instrument, medicine, drug, or any other substance or device with intent to terminate the pregnancy of a woman known to be pregnant, for reasons other than to save the life or preserve the health of an unborn child, to remove a dead unborn child, or to deliver an unborn child prematurely, by accepted medical procedures in order to preserve the health of both the mother and the unborn child.

2. The nature and purpose of the procedure to be performed, the possible alternative methods of management, the usual risks and consequences associated with the procedure, including the risks appicable to any surgical procedure, have been explained to me.

3. I authorize the administration of such anesthetic or paranesthetic medications as may be applied under the medical direction of East Carolina Anesthesia Associates and/or Local Anesthesia (by operating surgeon) except that I do not authorize the administration of the following: (list exceptions)

   _____

4. It has also been explained to me that, during the course of the operation, unforseen conditions may necessitate operations and procedures other than those set forth in Paragraph 1 and administration of anesthetic or paranesthetic medication other than those specified in Paragraph 3. In that event, I authorize the physician named in Paragraph 1, and/or other authorized practitioner(s) and such assistants as may be selected by said physician to perform such operations and procedures as are, in their professional judgment, necessary and desirable, and I authorize the administration of such other anesthetic or paranesthetic medications as in the professional judgment of those persons listed in Paragraph 3 are necessary and desirable.

5. I authorize and direct Pathology Services or such others as it may deem appropriate to examine the products of conception and all other tissues and organs, as shall be removed by operation or biopsy performed upon me. I do further authorize and direct said Pathologist(s) to photograph retain for scientific purposes or dispose of such items except: (list exceptions)

   _____

6. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation of procedure.

A. 1. **To be completed by patients who are (1) 18 years of age or older or (2) who are less than 18 years of age but who are emancipated by having either been married or having obtained a judicial decree of emancipation.**

   I acknowledge and represent to my physician(s) and WakeMed that I am (check one box):
   - ☐ 18 years of age or older (attach copy of photographic identification) or
   - ☐ less than 18 years of age but have been married (attach copy of marriage certification and photographic identification) or
   - ☐ less than 18 years of age but have obtained a judicial decree of emancipation (attach a copy of judicial decree and photographic identification).

   2. Signature of Adult _____ Witness _____

B. To be completed by all patients other than those described in Section "A". Paragraphs 1 and either 2 or 3 must be completed.

   1. Signature of Unemancipated Minor Patient _____ Witness _____

   2. Signature of one of the following:

   I acknowledge and represent to the physician(s) identified above and WakeMed that I am (check one box):
   - ☐ a parent with custody of the minor, (attach copy of photographic identification) or
   - ☐ the legal guardian or legal custodian of the minor (attach copy of photographic identification and legal documentation of guardianship or custody), or
   - ☐ a parent with whom the minor is living, (attach copy of photographic identification) or
   - ☐ a grandparent with whom the minor has been living for at least 6 months immediately preceding the date of the minor's written consent (attach copy of photographic identification).

   Signature of Adult _____ Witness _____

   Print name of Adult _____

3. In the alternative to completing paragraph B(2), attach a copy of the court's findings of fact and conclusions of law or such other court documentation supporting its decision to waive the requirement for consent described in B(2). Check that legal document is attached.

GUIDELINES FOR CONSENT TO NON-EMERGENCY ABORTION

PURPOSE: To properly document the informed consent for non-emergency abortion.

The consent may not be signed after a pre-operative medication has been given. Please contact the physician when the medication has been given and the consent not signed.

Fill in the date and the time (military) the consent was signed.

1. a. Physician name:
   (1) Write the physician's complete name
   (2) Teaching Service physicians use the attending's name only

   b. Legibly print or write the **FULL GIVEN NAME** of the patient.

2. ----------

3. List exceptions: List exceptions to medication not desired or allergy to controlled drugs: Otherwise write NONE.

4. ----------

5. List exceptions: List exceptions to disposal of products of conception, tissue and other organs. Otherwise write NONE.

6. ----------

A. 1. Check appropriate box. **FOR PATIENTS 18 YEARS OF AGE OR OLDER, AND "EMANCIPATED MINORS" ATTACH COPY OF PHOTOGRAPHIC IDENTIFICATION. FOR "EMANCIPATED MINORS", ALSO ATTACH JUDICIAL DECREE OF EMANCIPATION OR MARRIAGE CERTIFICATE.**

2. **PATIENT'S SIGNATURE REQUIREMENTS:**
   All signatures require one witness with the exception of two (2) witnesses required for:
   (a) Patient signing with an "X"
   (b) If the patient's signature is not legible

B. NOTE: COMPLETE PARAGRAPHS 1 AND EITHER 2 OR 3

1. **UNEMANCIPATED MINOR'S SIGNATURE REQUIREMENTS**
   All signatures require one witness with the exception of two (2) witnesses required for:
   (a) Patient signing with an "X"
   (b) If patient's signature is not legible

2. **CO-SIGNATORY'S SIGNATURE REQUIREMENTS**
   Check appropriate box. Print name of adult signatory. Obtain signature of person who qualifies to consent with minor for abortion. Persons meet this criteria by acknowledging and representing said relationship. Signature requirements are as in B.1.

   NOTE: ATTACH COPY OF PHOTOGRAPHIC IDENTIFICATION. ALSO, IF LEGAL GUARDIAN OR LEGAL CUSTODIAN (CHECKING SECOND BOX) ATTACH COPY OF LEGAL DOCUMENTATION.

3. **WHERE THERE IS NO CO-SIGNATORY IN B(2), ATTACH A COPY OF COURT DOCUMENTATION WHICH WAIVES THE PARENTAL CONSENT REQUIREMENT.**