

# Tipsheet For Referring Providers Completing NC Abortion Consent Forms

1. First, determine if the patient is obtaining a MEDICAL or SURGICAL abortion and sign the appropriate consent form.
  - a. If > 12 weeks gestation, the abortion must be performed surgically.
  - b. If ≤ 12 weeks, it is strongly recommended that both forms are signed even if patient is relatively certain which type they will pursue, in order to ensure options aren't limited if situation changes. Of note, typically medication abortion is offered up to 11w0d.

Medication - <https://www.ncdhhs.gov/ncdhhs-medical-abortion-informed-consent-english/download>

Surgical - <https://www.ncdhhs.gov/ncdhhs-surgical-abortion-informed-consent-english/download>

2. Complete patient name and date of birth at the top of the form. **Do NOT use a patient sticker**

### 3. PAGE 1

**NCDHHS MEDICAL ABORTION CONSENT FORM AND ACKNOWLEDGEMENT OF RISKS STATEMENT**

By initialing each of the items below, I certify that I have received the following information about my care:

INITIALS The physician that will provide the abortion-inducing medication(s) is  NAME OF PHYSICIAN. **LEAVE BLANK**

If the specific physician is not known, or changes after the time of this consent, the name will be noted below. S/he will be physically present while the first abortion-inducing drug is administered.

S/he  does or  does not have local hospital admitting privileges at  HOSPITAL NAME, which offers obstetrical or gynecological care and is located at  HOSPITAL ADDRESS.

INITIALS which is within 30 miles from the facility where the abortion is being performed. S/he has liability insurance to cover malpractice in the performance of an abortion unless otherwise communicated.

Check if not applicable. **Check both "Check if not applicable" options to ensure patients are able to seek care either at UNC or an external abortion facility**

INITIALS If applicable, I have been given the name and contact information of the physician team that will take care of me in the case of any complications after the abortion.

Check if not applicable.

INITIALS The provider  does or  does not accept my insurance.

**(Optional)** If no hospital is located within 30 miles, the following may be the closest hospital:

S/he  does or  does not have admitting privileges. **Patient Signature**

By signing here  and initialing each of the items below, I certify that I have been orally informed, in-person, by a qualified health professional, of the following specific information, at least 72 hours before the first abortion-inducing medication was given.

4. Read the line-by-line provisions in the consent form to the patient
5. Ask the patient to initial **EACH** of the statements in the consent form

6. Ask the patient to print and sign their full name as well as time/date

I understand that I will undergo a medical abortion. The discomforts, risks, benefits, and alternatives of the procedure have been explained to me. All my questions have been answered to my satisfaction. I also understand that my anonymous medical data will be released to representatives from the North Carolina Department of Health and Human Services as required by State law, and I understand that I can object in writing to having my medical records reviewed. My foregoing initials and signature and my signature below, confirm that I have voluntarily acknowledged and consented to each specific item listed above.

*NOTE: If the patient is less than 18 years old and does not have a court order allowing them to consent to an abortion, the person authorized by law to consent on their behalf must sign this certification form.*

SIGNATURE OF PATIENT/PERSON AUTHORIZED TO CONSENT	DATE AND TIME
PRINTED NAME OF PATIENT/PERSON AUTHORIZED TO CONSENT	RELATIONSHIP TO PATIENT (IF APPLICABLE)

I attest that I have provided this patient with the information presented above in-person.

SIGNATURE OF THE QUALIFIED PROFESSIONAL PROVIDING COUNSELING	DATE AND TIME
PRINTED NAME	

**Complete if physician is different than previously noted:**

I have informed the patient that the physician who will see them is Dr. \_\_\_\_\_.

S/he does have local hospital admitting privileges at \_\_\_\_\_.

STAFF INITIALS \_\_\_\_\_

**Patient Sign & Print Legal Name, Date & Time**

**Counseling Provider Sign & Print Legal Name, Date & Time**

**Per UNC Medical Center Policy: 13915359**

An unemancipated minor patient may receive an abortion if the attending Physician obtains the written informed consent of the minor patient and either: A waiver of parental consent is issued by a district court judge in accordance with N.C. Gen. Stat. § 90-21.7(b) and -21.8.

OR

The attending Physician obtains the written consent of one of the following:

- A parent with custody of the minor;
- The legal guardian or legal custodian of the minor;
- A parent with whom the minor is living; or
- A grandparent with whom the minor has been living for at least the previous six months.

In the event this subsection (b) applies, both the minor patient and one of the individuals listed above must give written informed consent as set forth in Sections III.D or E above, depending on the procedure.

7. As the counseling provider who has provided the information contained in the consent form, please print and sign your name as well as time/date.

8. Provide patient with a copy of the form regardless of where they will be receiving abortion care and instruct them to bring the form to all upcoming appointments.

9. If the patient might be seeking care at UNC, have the form IMMEDIATELY scanned into the Media tab of Epic entitled "GYN CONSENT" so as not to delay care.

10. If patient expresses confidentiality concerns and is certain not to be receiving abortion services through UNC, consider not scanning into Media tab and just giving patient a copy.

11. Place a referral for family planning in Epic if the care is desired through UNC. Also call Family Planning on-call directly if patient is close to 12 week cut-off (or 20 week cut-off for rape/incest.)

Order Number REF30 (Referral to Gynecology)

Specialty: Gynecology

**Referred To Department: UNC FAMILY PLANNING HILLSBOROUGH**

**\*This is required in order to avoid patient care delay.**