

The Bay Centre for Birth Control(BCBC)

76 Grenville St., 3rd Floor

Toronto ON, M5S 1B2

Tel: 416-351-3700 Fax: 416-351-3727

PATIENT IDENTIFICATION

INFORMED CONSENT FOR TELEMEDICINE MEDICATION ABORTION WITH MIFEPRISTONE and MISOPROSTOL

I have been counselled on my options, and I wish to proceed with a 'No/Low Touch' abortion. Women's College Hospital is following evidence-based protocols for No/Low Touch abortion endorsed by the National Abortion Federation.

I understand that I should not begin a medication abortion unless I am sure that I want to end my pregnancy, and that I will be counselled on my options including having a surgical abortion if the medication fails, since there is a risk that misoprostol may damage the current growing pregnancy.

I have fully disclosed to the best of my abilities my medical history including the date of my last menstrual period, allergies, history of anemia, bleeding disorders, ectopic pregnancies, medications and prior reactions to medications.

If necessary, based on clinical assessment of my symptoms and risk factors, I consent to:

- Ultrasound exam for the purpose of locating and dating the pregnancy
- Lab work for hemoglobin, STI testing and/or pelvic examination

I understand that without an ultrasound, the location of the pregnancy is uncertain. There is a small chance (1-2%) that I may have a tubal or ectopic (outside the uterus) pregnancy, which neither surgical nor medication abortion will remove. This uncertainty need not delay the abortion, however strict follow-up is very important to ensure resolution of the pregnancy. If an ectopic pregnancy is diagnosed, treatment with medicines, hospitalization or surgery may be necessary.

I understand that with these doses of mifepristone and misoprostol, there are no known long-term side effects. Short-term side effects include diarrhea, nausea, vomiting, abdominal pain, flatulence (gas), fever, chills, and headaches. Approximately 2-5% of women will either need or choose to have a surgical aspiration (dilatation and curettage or D&C) for ongoing pregnancy, too much bleeding, pain, or because they are tired of waiting to pass the pregnancy tissue. In comparison, the risk of a surgical abortion being incomplete and requiring a repeat D&C is less than 1%. Infections that can be treated with antibiotics occur in less than 1% of women and very rarely (less than 1/100,000) will a serious infection occur. The risk of a life-threatening event (hemorrhage, blood clot etc) should I choose to continue the pregnancy is 1/10,000.

I understand that I will be given prescriptions for pain medications and phone numbers to reach the clinic or the on-call provider if I experience any problems or have any questions after I leave the clinic.

I understand that one to five hours after I insert the misoprostol, I will experience cramping and bleeding. The bleeding can be heavy and there may be clots. I may see some pregnancy tissue. If the heavy bleeding lasts for more than 12 hours, or if I soak more than two pads each hour for two hours in a row, I know to go to the emergency room. I know that I should insert another dose of misoprostol 800 mcg and call the clinic if I do NOT bleed at all within 24 hours of inserting the misoprostol.

I understand that if I do not have OHIP/valid health coverage and cannot afford the WCH services related to medication abortion at BCBC, I will be provided them without charge. However, I acknowledge that in the rare situation that I require emergency care after the medication abortion, if I do not have OHIP/ valid health coverage, I may be required to pay a hospital and/or physicians for the emergency care.

I understand that it is very important that I complete a follow-up visit by phone or video to be sure that the abortion is complete. I know that at this plan will either involve a urine pregnancy test at 4 weeks or a blood test earlier depending on the assessment. If the abortion has not been completed, I will require an ultrasound and I will have the option of taking another dose or doses of the misoprostol or having a surgical aspiration to complete the abortion.

I have had the opportunity to review the information provided to me, and to discuss any questions I may have. I am making a voluntary and informed decision to request a medication abortion for termination of an early pregnancy preferably a no/low touch medication abortion as deemed reasonable following a clinical assessment and thorough discussion.

Patient's name (please print):

Patient's signature:

Date: ____/____/____
DD / MM / YYYY

Health Care Provider name (please print):

Health Care Provider signature:

Designation:

Date: ____/____/____
DD / MM / YYYY

