MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

Abortion Procedure Consent Form

FACILITY NAME

PATIENT NAME *(please print)*	PATIENT I.D. NUMBER *(for office use only)*

Massachusetts law requires you to sign this informed consent form prepared by the Massachusetts Department of Public Health (MDPH).

By signing my name below, I confirm that I have read, understand, and agree with the following statements:

- I consent to an abortion procedure, which will terminate my pregnancy.
- I may be offered local (small area of the body), general (all over the body), or other anesthesia to make the procedure more comfortable. I understand that general and other anesthesia come with more risk than local anesthesia.
- I understand that complications are rare with abortion procedures and may include:
  - infection;
  - heavy bleeding (hemorrhage);
  - the pregnancy or part of the pregnancy left in my uterus;
  - reactions to the medicines;
  - blood clotting problems;
  - a tear in the cervix or uterus;
  - injury to nearby organs;
  - hysterectomy (removal of the uterus) or;
  - death, which is extremely rare.
- I had the chance to ask questions and talk about my concerns with my health care provider.
- I know how to reach my health care provider, if needed.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PARENT/GUARDIAN *(if patient is under age 16 and has never been married)*	DATE

☐ Court authorization obtained.

This form shall be maintained solely by the facility as part of your confidential medical record.

MDPH Abortion Procedure Consent Form; last revised 2022. This consent form is available in multiple languages commonly spoken in Massachusetts. Email dph-abconsents@mass.gov to request additional languages.