

First :
DOB :
Chart# :

Medical Abortion Visit

*RH
Factor*

Screening:

Date: _____

LMP _____ Normal / Abnormal Gestation by LMP _____ Allergies: _____

Ht _____ Wt _____ T _____ P _____ BP _____ / _____ Hgb _____

LSPT: _____ HSPT: _____ Staff Signature _____

_____ The patient denies having any of the following conditions:

- hemorrhagic disorder
- current anticoagulant therapy
- current or severe anemia
- chronic adrenal failure
- confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass
- inherited porphyrias
- IUD in place (must be removed before treatment)
- allergy to mifepristone, misoprostol, or other prostaglandin
- current illness with significant diarrhea
- long-term systemic corticosteroid therapy

_____ The patient has no contraindications to surgical abortion at CMG

Patient Education:

The following has been discussed with the patient:

- _____ Patient is aware of alternatives to abortion, and has given informed consent
- _____ Patient understands the misoprostol insertion process and aftercare instructions, how to take pain medication, and how to monitor bleeding with sanitary pads
- _____ Effectiveness rate for mifepristone regimen is at least 95%, but can fail
- _____ Risk of serious fetal anomalies with mifepristone and misoprostol: once mifepristone has been administered, the abortion must be completed either medically or surgically; patient agrees to surgical abortion if necessary
- _____ Patient must return to CMG for ultrasound confirmation of complete abortion
- _____ Patient advised to discontinue breastfeeding, if applicable
- _____ Manufacturer's Patient Agreement and Guide - with "refer to CMG instructions" added - signed and given to patient (copy of agreement in chart and provided to patient)
- _____ Informed consent form signed for both medical abortion and surgical abortion
- _____ Patient instructed to begin hormonal contraceptives after completion of follow-up visit, if applicable

Follow-up appointment Date: _____ Time: _____

Misoprostol Insertion: Date: _____ Time: _____ Location: _____ Phone #: _____

Support person and relationship: _____ Follow-up call requested? Yes No

Notes: _____

Physical Exam and Ultrasound:

Thyroid: _____

Heart: _____

Lungs: _____

Abdomen: _____

U/S: _____

Gestation by U/S: _____

Other: _____

Medications:

_____ Mifepristone 200 mg Date: _____ Time: _____

ID#: _____ Exp: _____

_____ Immune globulin (MicRhogam) 50 mcg IM

Site: _____ Lot#: _____ Exp: _____

_____ Misoprostol 200 mcg disp #4

_____ Tylenol #3 disp #10

_____ Ortho-TriCyclenLO x 1 mo, 2 refills phoned to pharmacy

_____ Ortho Evra x 1 mo, 2 refills phoned to pharmacy

_____ Other _____

Pharmacy: _____ Phone #: _____

Clinician Signature: _____ Date: _____