UVA Health

0100001

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

24 HOUR ACKNOWLEDGEMENT NOTIFICATION

By signing this form, I am acknowledging that I have received information about the abortion procedure at least 24 hours prior to my appointment. This includes:

_____ (Patient's Initials)	I have been given a full and reasonable medical explanation of the nature, benefits, risks of and alternatives to the abortion procedure.
_____ (Patient's Initials)	I have been told that I may withdraw my consent at any time prior to the performance of the procedure.
_____ (Patient's Initials)	I have been offered a chance to speak with the physician who is to perform the abortion so that he/she may answer any questions I may have and provide further information concerning the procedure.
_____ (Patient's Initials)	I have been told the probable gestational age of the fetus (how many weeks pregnant) at the time my abortion is to be performed.
_____ (Patient's Initials)	I have been offered the chance to review the printed materials provided from the Department of Health. If I have chosen to review such materials, this information was provided to me at least 24 hours before the abortion or mailed to me at least 72 hours before the abortion by first class mail, or certified mail/restricted delivery.
_____ (Patient's Initials)	I have been offered the opportunity to view the ultrasound, receive a copy of the ultrasound and hear the fetal heart tones. _____ I accept the offer (Patient's Initials) _____ I decline the offer (Patient's Initials)

_____ _____ _____ _____

Signature of Patient or Legal representative | Printed name | Date | time

If Signed BY Person other than the adult Patient, Check relationship To Patient:

☐ 1. Agent named in advance directive ☐ 4. Adult Child ☐ 7. other Blood relative

☐ 2. Guardian ☐ 5. Parent ☐ 8. other* _____

☐ 3. Husband/Wife ☐ 6. adult Brother/Sister

for Minor Patients:

☐ 1. Parent's ☐ 2. Guardian or Legal Custodian ☐ 3. authorized person for child in out-of-home placement

*** Requires review and appointment by ethics Consult Service. See medical Center Policy 024, informed Consent.**

Clinic Use ONLY

By signing below, I am acknowledging that I have given the above information to

(Patient name)

about the abortion procedure at least 24 hours prior to her appointment.

Clinic Staff Signature _____ date _____ Time _____

Print name

interpretation attestation (when applicable)

Interpretation has been provided by: _____ _____ _____

Print name date Time

Signature of Interpreter/CyraCom Id# _____