



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 Signature _____ Date _____

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 and Time

Print Name

Interpretation Attestation (when applicable)

Interpretation has been provided by: _____ Date _____

Signature of Interpreter/CyraCom ID# _____