

ABORTION INFORMATION PROVISION CERTIFICATION

(Completion of this form by the patient is required under Wisconsin State Statute 253.10)

An exemption to the 24 hour wait period may be allowed if the pregnancy is the result of a sexual assault or incest or if there is a medical emergency.

_____ (name of physician) orally informed me, in person, on _____ (date) at _____ a.m./p.m. of the following:

That, according to my physician's reasonable medical judgment, I am pregnant and the probable gestational age of the fetus, on this date, is _____ weeks.

- 1. The probable anatomical and physiological characteristics of the fetus on this date.
- 2. That fetal ultrasound imaging and auscultation of fetal heart tone services are available that enable viewing the image or hearing the heartbeat of the fetus and how these services can be obtained.
- 3. The particular medical risks, if any, associated with my pregnancy.
- 4. The details of the medical or surgical method that would be used in performing or inducing an abortion.
- 5. The medical risks associated with the particular abortion procedure that would be used, including the risk of infection, psychological trauma, hemorrhage, endometritis, perforated uterus, incomplete abortion, failed abortion, or danger to subsequent pregnancies and infertility.
- 6. The recommended general medical instructions to follow after an abortion to enhance safe recovery and the name and telephone number of a physician to call if complications arise.

Physician's telephone number: _____

- 7. If, in the reasonable medical judgment of my physician, the fetus has reached viability, that the physician who is to perform or induce the abortion is required to take all steps necessary under law to preserve the life and health of the fetus.
- 8. That I have the right to withdraw consent, cancel the appointment or not show for the appointment at any time before the procedure is performed.
- 9. That no payment for the procedure may be required from me until at least 24 hours have elapsed after the informed consent consultation has been completed, except if the waiting period is shortened by me because the pregnancy is the result of sexual assault or incest.

I certify that this information was provided in an individual setting that protected my privacy, maintained the confidentiality of my decision and ensured that the information focused on my individual circumstances but that did not prevent me from having a person of my choice present. I certify that I was allowed adequate opportunity to ask questions and all my questions were answered in a satisfactory manner.

(patient)

(date)

(parent, guardian, legal custodian, adult family member, foster parent or treatment foster parent, if applicable for a minor)

(date)

(guardian of patient who has been adjudicated incompetent if applicable)

(date)

(name of physician or name and professional title of qualified person assisting the physician) orally informed me, in person, on _____ (date) at _____ a.m./p.m. of the following:

(The information noted in items 1-3 on this page may be omitted if the fetus has a diagnosis of a lethal anomaly.)

- 1. That benefits may be available to me under the Medical Assistance Program to pay for prenatal care, childbirth and neonatal care.
- 2. That the man responsible for my pregnancy is liable for providing assistance in supporting my child, if born, even if he has offered to pay for the abortion.
- 3. That I have the legal right to terminate my pregnancy or to continue my pregnancy and to keep my child, place my child in a foster home or treatment foster home for six months or petition a court for placement of the child in a foster home, treatment foster home or group home or with a relative or place the child for adoption under a process that involves court approval both of the voluntary termination of parental rights and of the adoption.
- 4. That I have the right to receive and review, free of charge, state-printed materials that contain information on the development of the fetus.
- 5. That, if I have received a diagnosis of a disability for the fetus, I have the right to receive and review free of charge, information on community-based services and financial assistance programs for children with disabilities and their families, support groups for people with disabilities and parents of children with disabilities, and adoption of children with special needs.
- 6. That I have the right to receive and review, free of charge, information on the availability of public and private agencies and services that provide birth control information including natural family planning information, agencies that offer alternatives to abortion, and information about legal protections for me and my child should I wish to oppose establishment of paternity or to terminate the father's parental rights.

The information listed in items 5 and 6 is available through a toll free telephone number 1-877-855-7296 as well as state-printed materials.

I certify that this information was provided in an individual setting that protected my privacy, maintained the confidentiality of my decision and ensured that the information focused on my individual circumstances but that it did not prevent me from having a person of my choice present. I certify that I was allowed adequate opportunity to ask questions and all my questions were answered in a satisfactory manner. I certify that the printed materials were physically given to me.

(patient) (date)

(parent, guardian, legal custodian, adult family member, foster parent or treatment foster parent, if applicable for a minor) (date)

(guardian of patient who has been adjudicated incompetent, if applicable) (date)

(To be filled in by the physician who is to perform or induce the abortion or qualified person assisting the physician)
The name of the physician who is to perform or induce the abortion is _____
Each item of information referred to in the nine numbered paragraphs on page one and the six numbered paragraphs on this page, must be supplied unless the physician determines a particular item of information would cause a significant, non-temporary threat of severe harm to the woman's mental health.
This form is to be placed in the patient's medical records and a copy provided to the patient.