

**State of Missouri**  
**Department of Health and Senior Services**  
**Informed Consent Checklist - Abortion**

I certify that the following information was given to me in person, orally and reduced to writing, at least 72 hours prior to the procedure, by a physician or other qualified professional.

Please initial each line.

\_\_\_\_\_ I have been provided the name of the physician who is to perform or induce the abortion and a contact number where the physician may later be reached if I have questions.

\_\_\_\_\_ I have had the opportunity to ask any questions of the physician who is to perform or induce the abortion concerning the abortion.

\_\_\_\_\_ I have been informed of any immediate and long-term medical risks associated with the proposed abortion method, anesthesia and medication that is to be administered, the gestational age of the fetus, and any medical conditions I have and medical history I have provided. (refer to pages 13-15 of the Informed Consent Booklet)

\_\_\_\_\_ I have been notified of alternatives to abortion and have been provided information concerning these options.

\_\_\_\_\_ I have been told the gestational age of the fetus and have been informed about the anatomical and physiological characteristics of the fetus. (refer to pages 3-12 of the Informed Consent Booklet)

\_\_\_\_\_ I have been given a description of the proposed abortion method. (refer to page 13 of the Informed Consent Booklet)

\_\_\_\_\_ I have been given the opportunity to view an active ultrasound. If I chose to view an active ultrasound at another provider, I was given a reasonable time to do so prior to the abortion being performed.

\_\_\_\_\_ I have been given the opportunity to hear the heartbeat of the developing fetus, if audible.

\_\_\_\_\_ I certify that the following information has been given to me:

- The booklet titled “Missouri’s Informed Consent Booklet” which provides information on: how your baby grows during pregnancy, methods of induced abortion and its risks, fetal pain, paternity information for moms and dads, information about child support, and information concerning alternative to abortions, including Missouri’s Alternatives to Abortion program.
- A List of Alternatives to Abortion Program Providers.
- A List of Pregnancy Assistance Information Providers.
- A List of Fetal Ultrasound Providers.

\_\_\_\_\_ I certify that the physician who is to perform or induce the abortion informed me orally and in person, at least 72 hours prior to the procedure, of

(1) The immediate and long-term medical risks to me associated with the proposed abortion method including, but not limited to, infection, hemorrhage, cervical tear or uterine perforation, harm to subsequent pregnancies or the ability to carry a subsequent child to term, and possible adverse psychological effects associated with the abortion; and

(2) The immediate and long-term medical risks to me, in light of the anesthesia and medication that is to be administered, the unborn child's gestational age, and my medical history and medical conditions.

\_\_\_\_\_ I understand that I am free to withhold or withdraw my consent for an abortion at any time without affecting my rights to future care or treatment and without the loss of any state or federally funded benefits to which I might otherwise be entitled.

\_\_\_\_\_ I certify that this information was provided in an individual setting that protected my privacy and maintained the confidentiality of my decision.

\_\_\_\_\_ I certify that my decision is voluntary and informed, free and without coercion.

**I attest that I was given all of the above information on:**

**Date** \_\_\_\_\_

**Time** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician/Qualified Professional:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician who is to perform the abortion:** \_\_\_\_\_ **Date** \_\_\_\_\_