

## **Feminist Women's Health Center Patient Privacy Notice Authorization**

In order to comply with new federal guidelines outlined in the Health Insurance Portability & Accountability Act of 1996 (HIPAA), a Federal law which seeks to protect the privacy of consumers' healthcare information, we are advising you of your right as to how your medical information may be used.

The *NOTICE OF PRIVACY PRACTICES* located in the waiting rooms of the clinic outlines how personal information about you may be used and how you can get access to this information. If you would like a paper copy of the *NOTICE OF PRIVACY PRACTICES* please ask and we will be glad to provide you with one.

**In accordance with the HIPAA Privacy Rule 45 CFR164.506** if you use a credit card to pay for services at Feminist Women's Health Center and subsequently dispute those charges with your banking institution/credit card holder, FWHC has the right to release some portions of your medical record should a financial dispute occur. By signing this form I certify that I fully understand this Privacy Notice and the rights of both myself and the FWHC.

---

I authorize the Feminist Women's Health Center to communicate medical information pertaining to my care by the methods outlined in the *NOTICE OF PRIVACY PRACTICES*. I am aware that I may ask for a paper copy of the *NOTICE OF PRIVACY PRACTICES* at any time.

Client signature \_\_\_\_\_

Witness \_\_\_\_\_

---

### **Valuables disclaimer (all patients must sign or be rescheduled):**

- I attest that I deposited my valuables with my driver or otherwise secured them to the best of my ability.
- I release Feminist Women's Health Center from any liability from lost or stolen property.
- I attest that I do not have any removable appliances in my mouth.

Client Signature \_\_\_\_\_

Witness \_\_\_\_\_

# Feminist Women's Health Center

## Request for Information

We are an inclusive organization that serves people of all identities, across age, ethnicity, race, nationality, gender and sexual orientation. We are interested in learning about the identities that you hold and the ways in which they affect how you experience the world.

**The following questions are optional, please share as much as you are comfortable:**

### 1. Please indicate your race:

- |   |   |
|---|---|
| <input type="checkbox"/> Asian/South Asian/Central Asian    | <input type="checkbox"/> Multiracial                    |
| <input type="checkbox"/> Black and/or African-American      | <input type="checkbox"/> White/Caucasian                |
| <input type="checkbox"/> Middle Eastern or North African    | <input type="checkbox"/> Prefer not to answer           |
| <input type="checkbox"/> Native American or Alaska Native   | <input type="checkbox"/> Prefer to self-describe: _____ |
| <input type="checkbox"/> Hispanic, Latinx or Spanish origin |   |

### 2. Please indicate your current school or highest degree obtained:

- |   |   |
|---|---|
| <input type="checkbox"/> Less than high school diploma          | <input type="checkbox"/> Bachelor's Degree    |
| <input type="checkbox"/> High School Degree or Equivalent (GED) | <input type="checkbox"/> Post Graduate Degree |
| <input type="checkbox"/> Associate Degree                       |   |

### 3. Please indicate your relationship status:

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Single    | <input type="checkbox"/> Legally Separated |
| <input type="checkbox"/> Married   | <input type="checkbox"/> Divorced          |
| <input type="checkbox"/> Partnered | <input type="checkbox"/> Widowed           |

### 4. Please indicate how you heard about the Feminist Women's Health Center:

- Been here before
- Friend/Word of Mouth
- Feminist Center event
- Health Fair
- Internet/Google Search
- National Abortion Federation (NAF) hotline
- Planned Parenthood
- ARC Southeast
- Physician/Referral: \_\_\_\_\_
- Other: \_\_\_\_\_

### 4. Sexual Orientation - Please select all identities that describe you:

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Asexual     | <input type="checkbox"/> Queer                          |
| <input type="checkbox"/> Lesbian     | <input type="checkbox"/> Gay                            |
| <input type="checkbox"/> Questioning | <input type="checkbox"/> Straight/Heterosexual          |
| <input type="checkbox"/> Bisexual    | <input type="checkbox"/> Prefer not to answer           |
| <input type="checkbox"/> Pansexual   | <input type="checkbox"/> Prefer to self-describe: _____ |

**4. Gender Identity – Please select all the identities that describe you:**

- Woman
- Man
- Two-Spirit
- Intersex
- Trans Man/ Man of trans experience
- Trans Woman/ Woman of trans experience
- Prefer not to answer
- Prefer to self-describe\_\_\_\_\_

**7. Please indicate the combined annual income level for your entire household:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Less than \$20,000   | <input type="checkbox"/> \$35,000 to \$49,999 | <input type="checkbox"/> \$75,000 - \$99,999 |
| <input type="checkbox"/> \$20,000 to \$34,999 | <input type="checkbox"/> \$50,000 - \$74,999  | <input type="checkbox"/> Over \$100,000      |

**9. Please indicate the number of family members in your household, including yourself:**

- 1
- 2
- 3
- 4
- 5
- More than 5

**Feminist Women's Health Center's  
Cliff Valley Clinic  
Client Certification form**

Today's Date, \_\_/\_\_/\_\_

I, \_\_\_\_\_, request that an abortion be performed on me;

Printed name

I certify that I am \_\_\_\_\_ years of age, date of birth \_\_/\_\_/\_\_\_\_.

**I certify that:**

I do not chose to view the state materials as at least twenty-four (24) hours before the abortion, the physician who is to perform the abortion, the referring physician, or his or her qualified assistant has told me, by telephone, in person, or by automated script on Date, \_\_/\_\_/\_\_ Time, \_\_\_\_\_

- The probable gestation of the fetus or embryo based on my last menstrual period
- The particular medical risks to me of the procedure that is indicated by my probable gestation
- The medical risks to me if I carry this pregnancy to term
- That medical assistance benefits may be available to me for prenatal care, childbirth and neonatal care
- That the father would be liable for child support per Ga. Code 19-7-49
- That I have the right to review State supplied materials, on the State of Georgia Website (or printed materials in the clinic or by mail at least 24 hours before my appointment) that describe the fetal development of the unborn child, contain information on fetal pain and contains a list of agencies that provide alternatives to abortion and free ultrasounds.
- I consent to the particular abortion freely and without coercion of any person and I am not under the influence of any drug of abuse or alcohol
- I was provided the opportunity to ask questions about the abortion that will be performed and all of my questions have been answered to my satisfaction

I verify that this information is correct and accurate.

Client's Signature \_\_\_\_\_

Translator Signature \_\_\_\_\_

Witness Signature \_\_\_\_\_

Physician Signature \_\_\_\_\_

**Or:** I chose to view the State written materials which results in another mandatory 24 hour wait period.

I will return to the clinic on the next available date \_\_\_\_\_ . Initials \_\_\_\_\_

**Feminist Women's Health Center's  
Cliff Valley Clinic**

HB 147/Client Ultrasound Certification Form

\*\*\*\*\*As part of the pre-abortion process, we will perform an ultrasound. If for any reason you leave our facility after the ultrasound, you will be charged a 140 dollar ultrasound fee. \*\*\*\*\*

Description

In accordance with the "Women's Ultrasound Right to Know Act" Chapter 9A of Title 31 Official Code of Georgia annotated, relating to the "Women's Right to Know Act", facilities performing abortions in the state of Georgia must offer each woman seeking an abortion the opportunity to view an active image of the ultrasound and to hear the fetal heart tones if they are present and audible.

The **choice is yours** whether to look at the ultrasound or listen to the fetal heart tones. You are not required to look or listen.

Attestation:

I was offered the opportunity to look at the ultrasound and to hear the fetal heart tones (if present) today, \_\_\_\_\_.  
DATE

I choose (check 1 box):

**Not to look at** the sonogram                       **To look at** the sonogram

I choose (check 1 box):

**Not to listen** to the fetal heartbeat                       **To listen** to the fetal heartbeat (if present)

**I understand that this sonogram determines gestational age only and does not determine the presence or absence of any fetal malformation.**

**CLIENT SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

OFFICE USE BELOW THIS LINE

**Fetal Ultrasound Report**

*Early Pregnancy Protocol:*

# of Fetus:     0     1     2     3

Abdominal Pain:     YES     NO

# of Sacs:     0     1     2     3

Bleeding since LMP:     YES     NO

YOLK SAC SEEN:     YES     NO

L Adnexa     MASS     NO MASS

FHT:     YES                       NO                       NOT SEEN

R Adnexa     MASS     NO MASS

**FIBROID:**     YES PLACEMENT \_\_\_\_\_

Per:     Pelvic Exam     Vaginal U/S

**PLACENTA:**     Anterior             Posterior             Fundal             Previa

Abdominal Ultrasound                       Transvaginal Ultrasound

**FL:** \_\_\_\_\_ **BPD:** \_\_\_\_\_ **CRL:** \_\_\_\_\_ **WEEKS:** \_\_\_\_\_

**HEIGHT:** \_\_\_ft \_\_\_in    **WEIGHT:** \_\_\_\_\_ lbs.    **BMI:** \_\_\_\_\_

**ULTRASOUND TECHNICIAN:** \_\_\_\_\_

**MD SIGNATURE:** \_\_\_\_\_

FEMINIST WOMEN'S HEALTH CENTER  
MEDICAL HISTORY

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Legal Name \_\_\_\_\_ Preferred Pronoun (he/she/ze) \_\_\_\_\_

Preferred Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_ Phone (c) (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

City \_\_\_\_\_ Within City Limits: Yes  No  (h) (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ (w) (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

At what phone # may we contact you? \_\_\_\_\_ May we leave a message: Yes ( ) No ( )

Emergency contact: Name \_\_\_\_\_ Phone: \_\_\_\_\_

Does your emergency contact know that you're having an abortion? Yes  No

Preferred language: \_\_\_\_\_ Do you need assistance to fill out this form? Yes  No

If not English speaking, Interpreter's name \_\_\_\_\_

Pharmacy # \_\_\_\_\_

DRUG/FOOD/LATEX ALLERGIES: \_\_\_\_\_

CURRENT MEDICATIONS/ VITAMINS/ HERBAL SUPPLEMENTS: \_\_\_\_\_

FREQUENCY & LAST TAKEN: \_\_\_\_\_

Please check any of the following that apply:

**OB History:**

Complete below:

1. Total No. Pregnancies including current: \_\_\_\_\_ Living children: \_\_\_\_\_

Live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_ at this facility? Y  N

Ectopic/tubal: \_\_\_\_\_ Other: \_\_\_\_\_

# of C-sections: \_\_\_\_\_ Last pregnancy when: \_\_\_\_\_

Problems with pregnancies: (high blood pressure, seizures, preeclampsia, gestational diabetes, birth defects) other: \_\_\_\_\_

2. First day of last period \_\_\_\_/\_\_\_\_/\_\_\_\_ Normal  Abnormal

3. Are your monthly cycles:  Regular  Irregular  Light  Heavy  
 Mild cramps  Severe cramps

4. Are you Rh neg: Y  N  Have you received Rhogam: Y  N

**GYN History:**

5.  Have you ever had a pelvic exam/ Pap smear? Date of last exam \_\_\_\_\_

6.  Abnormal Pap (date) \_\_\_\_\_

Treatment: Repeat pap (date) \_\_\_\_\_

Colpo/Cryo/LEEP/Laser

7.  Breast disease or surgery/nipple discharge/leaking

8.  Are you breast feeding/nursing

9.  Vaginal infections/itching /burning /pain / bumps/ swelling/ sores

10.  Sexually transmitted infections (Circle all that apply):  
Herpes, HPV, Chlamydia, Gonorrhea, Trichomonas, Syphilis,  
HIV, Hepatitis B

11.  Pelvic inflammatory disease (PID) Date \_\_\_\_\_

Treatment: \_\_\_\_\_

12.  Uterine fibroids/ endometriosis

13.  Cysts on ovaries

14.  Genital circumcision

15.  Bleeding and/or pain with sex

**Contraception:**

16. How have you prevented pregnancy in the past? \_\_\_\_\_

17. When, if ever, would you like to be pregnant again? \_\_\_\_\_

**Social History: (The Feminist Women's Health Center is legally required to follow Georgia state law regarding the report of statutory rape and child abuse.)**

Y N

18.   Have you ever been forced to engage in sexual activity of any kind against your will?  
19.   Are you now or have you ever been in an abusive relationship?  
20.   Have you been treated for/ received counseling for emotional/mental illness?

**Personal Medical History:**

21.   Hearing impaired. Do you know sign language Yes ( ) No ( )  
22.   Heart problems/palpitations/murmurs/surgery/valve replacement  
23.   High Blood Pressure/ medications: \_\_\_\_\_  
24.   Strokes/Blood Clots in head, heart, brain, lungs, legs/Head injury  
25.   High cholesterol/ blood fats  
26.   Diabetes/High Sugar: (insulin/pills/diet) Only with pregnancy  
27.   Bladder/Kidney problems/infections  
28.   Headaches/migraine, stress related or other  
29.   Seizures/epilepsy: Date of last seizure \_\_\_\_\_  
30.   Liver disease/Hepatitis  
31.   Stomach or bowel problems/gastritis/ ulcers/reflux disease/Colitis/IBS/Crohns  
32.   Gallbladder disease/Surgery  
33.   Thyroid conditions/ medications  
34.   Lung Problems/Disease/Asthma=(circle one) Childhood, Seasonal; Chronic  
35.   Do you have a history of drug or alcohol abuse?  
36.   Do you smoke? If yes, how many cigarettes per day? \_\_\_\_\_  
37.   Have you ever used crack, cocaine, pcp or another street drug in the past?  
Date of last use: \_\_\_\_\_  
38.   Anemia/Low Iron/Sickle Cell/Thalassemias/Blood diseases/Lupus  
39.   Cancer/ type: \_\_\_\_\_  
40.   Are you currently under care for a problem/illness by a health care professional? Explain \_\_\_\_\_  
41.   Have you ever been hospitalized for any reason except for childbirth?  
Explain \_\_\_\_\_  
42.   Received blood products? Year: \_\_\_\_\_ Reason Received: \_\_\_\_\_  
43.   Do you faint with needles/finger sticks/pap smears  
44.   Have you ever been put to sleep for any surgery? Did you have any problems-Y N  
45.   Do you have any piercings in your mouth or are you wearing glasses/contact lenses today?

**Family History:**

**Adopted: Y  N**

Fill in below: mom, dad, siblings, grandparents, aunts, and uncles

46.  Diabetes \_\_\_\_\_  
47.  Problems with anesthesia \_\_\_\_\_  
48.  Heart attack before age 50 \_\_\_\_\_  
49.  High Blood Pressure \_\_\_\_\_  
50.  Cancer (breast, ovarian, uterus) \_\_\_\_\_  
51.  Strokes/Blood Clots in head, heart, brain, lungs, legs \_\_\_\_\_

- What other information or referrals may we provide for you? \_\_\_\_\_
- I affirm that I have been counseled about available options for birth control, including the benefits and risks of the method I have chosen: \_\_\_\_\_ (method(s))
- I affirm that all of the medical information stated above is true and that I have not had anything to eat, drink or gum since: \_\_\_\_\_

Client signature \_\_\_\_\_ Date/Time: \_\_\_\_\_ Updated: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Counselor signature \_\_\_\_\_ Date/Time: \_\_\_\_\_ Updated: \_\_\_\_\_ Date/Time: \_\_\_\_\_

RN Pre-op Signature \_\_\_\_\_ Date/Time: \_\_\_\_\_ Updated: \_\_\_\_\_ Date?Time: \_\_\_\_\_

MD/NP Review \_\_\_\_\_ Date/Time: \_\_\_\_\_ Updated: \_\_\_\_\_ Date/Time: \_\_\_\_\_

CRNA Review \_\_\_\_\_ Date/Time: \_\_\_\_\_ Updated: \_\_\_\_\_ Date/Time: \_\_\_\_\_

**FEMINIST WOMEN'S HEALTH CENTER  
CLIFF VALLEY CLINIC**

**CLIENT COUNSELING NOTES**

**NAME** \_\_\_\_\_

**DATE** \_\_\_\_\_

**I certify that the client states she is fully aware of the risks and possible complications of the abortion procedure. The client has voluntarily requested termination of her pregnancy at Feminist Women's Health Center and gives her consent to same without coercion. All consent forms have been reviewed and client is firm in her decision.**

**If client is receiving General Anesthesia, she attests that she is NPO.**

**Signature (Physician's Qualified Agent)** \_\_\_\_\_

.....

**OVERNIGHT D&E CLIENT NPO CERTIFICATION**

**I certify that I have not had anything to eat or drink since 12:00 am today. This includes gum, water or mints. I further understand that failure to disclose that I am not NPO can lead to serious anesthesia complications including death.**

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature (Physician's Qualified Agent)** \_\_\_\_\_ **Date** \_\_\_\_\_



## PRE-OPERATIVE & OPERATIVE NOTES

NAME \_\_\_\_\_

DATE \_\_\_\_\_

**PRE-PROCEDURE NOTES:**

VS: BP \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_ Temp \_\_\_\_\_ Time \_\_\_\_\_ Staff Sig \_\_\_\_\_

VS: BP \_\_\_\_/\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_ Temp \_\_\_\_\_ Time \_\_\_\_\_ Staff Sig \_\_\_\_\_

**Pre op exam**

Date \_\_\_\_\_ Time \_\_\_\_\_

N A      N A

Heart   Lungs   (1 day procedure only)

I.V. started Yes  No  Site \_\_\_\_\_ Angiocath size \_\_\_\_\_ # of attempts \_\_\_\_\_ Time started \_\_\_\_\_

IVF \_\_\_\_\_ 1000 ml Yes  No  Rate \_\_\_\_\_/hour

Standing Medication Orders:

Azithromycin 250mg po Yes  No  Time \_\_\_\_\_

Cytotec 400 mg buccal Yes  No  Time \_\_\_\_\_

Ibuprofen 800mg po Yes  No  Time \_\_\_\_\_

Xanax 0.5mg po Yes  No  Time \_\_\_\_\_

Xanax 1mg po Yes  No  Time \_\_\_\_\_

Zofran 4mg iv Yes  No  Time \_\_\_\_\_

Other \_\_\_\_\_

RN/CRNA Signature \_\_\_\_\_

Per Order of MD \_\_\_\_\_

Date \_\_\_\_\_

Patient cleared for IV conscious sedation /general anesthesia: Yes  No  NA  Findings: \_\_\_\_\_

**MD/CRNA Signature**

	Normal	Abnormal		Normal	Abnormal	Pre-operative Diagnosis
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Vagina	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perineum/Vulva	<input type="checkbox"/>	<input type="checkbox"/>	Cervix	<input type="checkbox"/>	<input type="checkbox"/>	_____
			Adnexa	<input type="checkbox"/>	<input type="checkbox"/>	_____

Anteverted  Mid-position  Anteflexed  Retroflexed  Retroverted  Time out performed @ \_\_\_\_\_

Special findings: \_\_\_\_\_

(D&E) Physician Attestation: It is my intention to complete the abortion by removing the fetus in multiple parts. \_\_\_\_\_  
MD initials

**PROCEDURE NOTES:**

Surgical Procedure: Start Time \_\_\_\_\_ Ending Time \_\_\_\_\_

Removed: Laminaria \_\_\_\_\_ Lamitel \_\_\_\_\_ Gauze \_\_\_\_\_

Dilation to \_\_\_\_\_ Fr Cannula \_\_\_\_\_ mm Misoprostol \_\_\_\_\_ mcg \_\_\_\_\_ cc \_\_\_\_\_ %Xylocaine

Vasopressin:  Yes  No Procedure: D&E  VA

Special Finding or Problems \_\_\_\_\_

Abortion Felt Complete  Yes  No Ultrasound Guided  Yes  No EBL: \_\_\_\_\_

(D&E) The Fetus  was removed in multiple parts, fetal parts were morselated with instrumentation in utero  was not removed in multiple parts

Comments: \_\_\_\_\_

Post-operative Diagnosis \_\_\_\_\_ Transported via stretcher to AC \_\_\_\_\_

MD Signature \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

Medications	Ordered by Physician	RX given or Administered by RN (Date/time)
Ferrous Sulfate 325 mg 1PO daily		
Tylenol 3 w/Codeine PO q4-6hr PRN		
Ortho Evra		
Nuvaring		
Oral Contraceptive: _____		
Minigam/ Rhogam IM		
Methergine 0.2mg <input type="checkbox"/> IM <input type="checkbox"/> PO		
Depo Provera 150 mg IM		
IV fluids D5LR with 40u Pitocin		
Toradol _____ mg <input type="checkbox"/> IM <input type="checkbox"/> IV		
Ibuprofen 800mg PO x1		
Benadryl 50mg/ml <input type="checkbox"/> IM <input type="checkbox"/> IV		
Zofran 4mg <input type="checkbox"/> IV <input type="checkbox"/> IM		
Additional Orders: _____		
Azithromycin 1 gm PO x 1		
Other Antibiotic: _____		

Physician

Signature: \_\_\_\_\_ Nurse Signature: \_\_\_\_\_

Nurse's Aftercare Notes

**VS/Bleeding/Cramping:**

Time \_\_\_\_\_  
 BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_  
 SaO2 \_\_\_\_\_

Time \_\_\_\_\_  
 BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_  
 SaO2 \_\_\_\_\_

Time \_\_\_\_\_  
 BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_  
 SaO2 \_\_\_\_\_

**Bleeding:**      **Cramping:**  
 Spotting       none   
 Light       mild   
 Mod       mod   
 Heavy       severe

**Bleeding:**      **Cramping:**  
 spotting       none   
 light       mild   
 mod       mod   
 heavy       severe

Initials: \_\_\_\_\_

Initials: \_\_\_\_\_

Initials: \_\_\_\_\_

IV Fluids Received:  YES  NO

Amount Infused \_\_\_\_\_ ml      Amount Wasted \_\_\_\_\_ ml

Condition of IV site \_\_\_\_\_      Angiocath D/Cd: Time \_\_\_\_\_

*Aftercare Instructions* Given:  YES  NO *Iron Rich Food Sheet* Given:  YES  NO *Contraceptive Information* Given:  YES  NO

Additional Instructions/Documentation: \_\_\_\_\_

**Physician's Discharge Summary**

*Patient Ambulatory:*  YES  NO      *Patient Alert & Oriented:*  YES  NO      *Patient Stable:*  YES  NO  
*Patient discharged to:*  Husband  Relative  Friend  Other \_\_\_\_\_  Self (*exempted by physician, patient meets discharge policy criteria*).

Follow up required?  YES  NO

Notes: \_\_\_\_\_

Discharge Time \_\_\_\_\_

Physician Signature \_\_\_\_\_

Nurse Signature \_\_\_\_\_

Patient Signature \_\_\_\_\_