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:

- ☐ Asian/South Asian/Central Asian
- ☐ Black and/or African-American
- ☐ Middle Eastern or North African
- ☐ Native American or Alaska Native
- ☐ Hispanic, Latinx or Spanish origin
- ☐ Multiracial
- ☐ White/Caucasian
- ☐ Prefer not to answer
- ☐ Prefer to self-describe: _____

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

- ☐ Less than high school diploma
- ☐ High School Degree or Equivalent (GED)
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Post Graduate Degree

3. Please indicate your relationship status:

- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Legally Separated
- ☐ Divorced
- ☐ 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: _____

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

- ☐ Asexual
- ☐ Lesbian
- ☐ Questioning
- ☐ Bisexual
- ☐ Pansexual
- ☐ Queer
- ☐ Gay
- ☐ Straight/Heterosexual

☐ Prefer not to answer
☐ Prefer to self-describe: _____

6. 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:

☐ Less than $20,000
☐ $20,000 to $34,999
☐ $35,000 to $49,999
☐ $50,000 - $74,999
☐ $75,000 - $99,999
☐ 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 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:_____

PHYSICIAN'S AGENT: _____ Date:_____

Ultrasound Record

Date: _____

Patient: _____ DOB: _____

LMP: _____ EGA by LMP: _____ Height: _____ Weight: _____ BMI: _____

Ultrasound:

Technique: Abdominal Vaginal

Planes scanned: Longitudinal Transverse

Single gestation: □ Yes □ Multiple: _____

Intrauterine: □ Yes □ No

Yolk sac: □ Yes □ No

Cardiac activity: □ Yes □ No

Early Pregnancy Protocol (no yolk sac):

Abdominal pain: □ Yes □ No

Bleeding since LMP: □ Yes □ No

L Adnexa □Mass □ No Mass

R Adnexa □Mass □ No Mass

Per: □ Pelvic Exam □ Vaginal U/S

	Measurement	Gestational Age (weeks)
Mean Sac Diameter 1 2 3 Average	 mm mm mm	
Crown-Rump Length	mm	
Biparietal Diameter	cm	
Femur Length	cm	

Attach images here

Fibroid: □ Yes Placement _____

Placenta Location: Anterior Posterior

Fundal Previa

Notes

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Sonographer Signature: _____

Interpretation:

Intrauterine pregnancy at _____weeks ____days

Other: _____

MD Signature: _____

NAF Adapted/revised 9/2019 KP

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 **N A N A**
Date_____ Time_____ 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/vaginal	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
Abdomen	☐	☐	Vagina	☐	☐
Perineum/Vulva	☐	☐	Cervix	☐	☐
			Adnexa	☐	☐

Pre-operative Diagnosis
_____
_____
_____

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_____ Lamicel_____ 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 ☐ IM ☐ PO		
Depo Provera 150 mg IM		
IV fluids D5LR with 40u Pitocin		
Toradol _____mg ☐ IM ☐ IV		
Ibuprofen 800mg PO x1		
Benadryl 50mg/ml ☐ IM ☐ IV		
Zofran 4mg ☐ IV ☐ IM		
Additional Orders:_____		
Azithromycin 1 gm PO x 1		
Other Antibiotic:_____		

Physician Signature:_____ **Nurse Signature:**_____

Nurse's Aftercare Notes

VS/Bleeding/Cramping:

Time_____ **Time**_____ **Time**_____
BP_____**P**_____**R**_____ **BP**_____**P**_____**R**_____ **BP**_____**P**_____**R**_____
SaO2_____ **SaO2**_____ **SaO2**_____

Bleeding:	**Cramping:**		**Bleeding:**	**Cramping:**
Spotting ☐	**none** ☐		**spotting** ☐	**none** ☐
Light ☐	**mild** ☐		**light** ☐	**mild** ☐
Mod ☐	**mod** ☐		**mod** ☐	**mod** ☐
Heavy ☐	**severe** ☐		**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** _____