

INTERMOUNTAIN PLANNED PARENTHOOD

SENATE JUDICIARY

Exhibit No. 7

Date 2-2-05

Bill No. SB 330

REQUEST FOR THE PROVISION OF SURGERY OR OTHER SPECIAL SERVICES/PROCEDURES

Before you give your consent, be sure you understand the information below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I have been given information about the test(s), treatment(s), service(s)/procedure(s)/surgery to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that with any service/procedure/surgery, there is also the possibility of side effects. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee about the results from this service/procedure/surgery has been given to me. I know that it is my choice whether or not to have this service/procedure/surgery. I know that I can change my mind about receiving this service at Planned Parenthood at any time.

I understand that if tests for certain sexually transmitted infections are positive; reporting positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in InterMountain Planned Parenthood's Notice of Health Information Privacy Practices. I consent to the use and disclosure of my health information as described in Notice of Health Information Privacy Practices.

If there is an unexpected complication during the service/procedure/surgery, I request and authorize the clinician and authorize Planned Parenthood staff to do whatever is necessary to preserve my health and welfare. If I need to be referred to a hospital emergency room, you will require that I be transported by ambulance.

I request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including birth control drug or device, if I request it) and perform the following service(s)/procedure(s)/surgery.

I have been given the following Client Information Sheets:

- Early Surgical Abortion, Mid-Trimester D&E Abortion, Medical Abortion, Other, Cervical Preparation Using Osmotic Dilators/Misoprostol, IV Sedation, Rh(o) Immune Globulin Injection, Ultrasound, Small Amount of Tissue (pathology)

Lab tests as indicated:

- RH Factor, Hematocrit, Chlamydia, Gonorrhea Culture, Wet Mount, QBHCG, Pregnancy Evaluation

Signature of Patient _____ Date _____

I witness the fact that the patient received the above-mentioned information and said she read and understood the same and had the opportunity to ask questions.

Signature of Witness _____ Date _____

Box containing: CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW, Signature of any other person consenting, Relationship to patient, I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above-mentioned information and said she/he read and understood same, Signature of Witness, Date