CONSENT FORM FOR MTP BY MMA

I have been explained about the process of medical method of abortion, which is a method to terminate a pregnancy using a combination of two medicines. I understand that I will be required to take the prescribed doses of mifepristone on Day1, followed by misoprostol on Day 3. I also understand that i will be required to come to the clinic for a follow up visit on Day 15 to confirm the completion of the procedure.

I understand that many women experience some side effects with medical methods of abortion such as nausea, vomitting, diarrhoea, abdominal pain, cramping and bleeding. The bleeding may be heavier than I usually experience during my menstruation.

My Doctor/Counsellor has also explained that there are chances that the method may fail to terminate the pregnancy. In such a situation, it will be necessary for me to undergo a surgical abortion to complete the process. If I experience any symptoms identified by my Doctor as danger signs, or if I have any concerns about the procedure during the course of the 15 days, I may call my Doctor.

I _____ daughter/wife of _____ aged about _____ years residing at

_____

do hereby give my consent for the termination of my pregnancy at _____

_____

Place : _____

Date : _____

Signature.

I _____ son/daughter/wife of _____ aged about _____ years residing

at _____ do

hereby give my consent for the termination of the pregnancy of my ward _____ who is a minor/

mentally ill person at _____

Place : _____

Date : _____

Signature.