

PATIENT INFORMATION

(Please print clearly)

All information **must** be correct and complete.

PATIENT NAME _____
First Name Middle Initial Last Name

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

*PHONE _____ May we leave a message or contact via mail? YES NO

*In the instance that we may need to contact you.

COUNTY: _____ RACE: _____

MARITAL STATUS: ___M ___S ___D ___W

EMPLOYER'S NAME: _____ PHONE: _____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

REFERRING PHYSICIAN: _____

OTHER SOURCE: _____

PAYMENT ARRANGEMENT: (READ CAREFULLY)

Payment is expected in full amount before services are rendered. ONLY CASH, VISA, MASTERCARD, AND DISCOVER CARDS ACCEPTED.

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION:

I fully comprehend the privacy notice given to me by Alamo Women's Clinic (San Antonio) or Coastal Birth Control Center (CBCC) Corpus Christi. I understand I must complete a medical release form in order to receive copies of my medical records or in order to have any of my medical information released to any person or facility. There is a fee for the release of medical records. I authorize the clinical staff to contact and give information about my medical condition in the event of an emergency and/or to the emergency contact person listed above.

WE RESERVE THE RIGHT TO REFUSE SERVICES:

To any person requesting an abortion who does not have the appropriate identification, is unaccompanied by a driver on the day of the abortion procedure or on any day on which sedation is administered, is under the influence of alcohol, illegal drugs and / or prescription medication(s) which in any manner may alter the patient's ability to make an informed consent, or any abusive behavior.

I have received the "Pregnancy, Parenting and Emotional Distress Resource List " _____

DATE _____ PATIENT SIGNATURE _____ Patient's Initials _____

PARENT SIGNATURE _____

FOR OFFICE USE ONLY

Pre-Admission / 24 Hour Patient Information Date: _____ Time: _____ am/pm

Procedure Date: _____ Time: _____ am/pm

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information or treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment to disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies of your records a \$50.00 duplication fee will be charged for staff time to locate and copy your health information, and postage if you want the copies mailed.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (exception in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. (Your requests must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Julio Aquino, Office Manager

Address: 1901 Morgan Avenue, Corpus Christi, Texas 78404

**ACKNOWLEDGEMENT OR REVIEW OF
NOTICE OF PRIVACY PRACTICE**

I have reviewed Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Print Name (Patient)

Patient Signature

Parent Signature

Staff Witness

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- () Individual refused to sign.
- () Communication barriers prohibited obtaining the acknowledgement.
- () An emergency situation prevented us from obtaining acknowledgement.
- () Other (please specify):

This questionnaire is part of your medical record and is used by staff to anticipate any problems you might have relating to your appointment. This record is strictly confidential. Please do not leave anything blank.

Patient Information:

Name _____ Nickname _____
Date of Birth: _____ Age _____ Occupation _____

Menstrual History:

What was the first day of your last period? Was it normal? _____

What is the usual length of your period? (# of days bleeding) _____

Are your periods ever more that a month apart? _____

Pregnancy History:

Total number of times you have been pregnant including today? _____

Number of Vaginal Deliveries _____ Number of C-Sections _____

Number of Miscarriages _____ Number of Abortions _____ Number of Ectopic Pregnancies _____

Complications Related to any _____

Has the pregnancy been confirmed by any of the following:

urine test at home urine test at a clinic blood test at a clinic none

Personal Medical History (PLEASE CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> Anemia/Sickle Cell | <input type="checkbox"/> HIV Positive or AIDS |
| <input type="checkbox"/> Asthma: Do you use an inhaler? _____ | <input type="checkbox"/> Infection in your tubes or uterus |
| <input type="checkbox"/> Bad chest pains or unusual shortness of breath | <input type="checkbox"/> Loss of sight or fuzzy vision |
| <input type="checkbox"/> Bladder or kidney infection | <input type="checkbox"/> Lumps in your breast or discharge |
| <input type="checkbox"/> Bleeding in between periods | <input type="checkbox"/> Migraine or severe headache |
| <input type="checkbox"/> Blood clots in your legs or lungs
(Thrombophlebitis or pulmonary embolus) | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Cancer of the uterus, vagina, cervix, or breast | <input type="checkbox"/> Pelvic Inflammatory disease (PID) |
| <input type="checkbox"/> Chlamydia, gonorrhea, herpes, HPV | <input type="checkbox"/> Psychiatric/Nervous disorder |
| <input type="checkbox"/> Diabetes, hypoglycemia or sugar in your urine | <input type="checkbox"/> Depression/Suicidal tendencies |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Epilepsy, convulsions, seizures | <input type="checkbox"/> Trichomoniasis/ Bacterial vaginosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart murmur: medication? | <input type="checkbox"/> Yeast infection |
| <input type="checkbox"/> High blood pressure/hypertension | <input type="checkbox"/> Smoke cigarettes # _____ per day |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Alcohol consumption |
| | <input type="checkbox"/> Illicit drug use or addition |

Allergic to any medications? No/Yes If yes, please list: _____

Do you take any medications? No/Yes If yes, please list: _____

Have you ever been hospitalized? No/Yes If yes, please describe and date _____

Have you ever had any surgeries? No/Yes If yes, please describe and date _____

Have you ever had a PAP Smear? No/Yes If yes, please describe and date _____

Did you try any other abortion methods before coming here? _____

Please list any other health concerns not listed above _____

Pharmacy Name and Number _____

Patient Signature _____ **Date** _____

24 Hour Information Certification Document
"A Woman's Right to Know"

Each item on this certification document must be reviewed at least 24 hours before the abortion procedure. The patient should place her initials beside each statement and sign the back of the document. If patient is a minor, then her parent or legal guardian must also initial next to each statement and sign the back of the document.

I certify that the following information was presented to me, at least 24 hours prior to the abortion, by the physician who is to perform the abortion or the referring physician.

The following number is a recording of the abortion procedures:

San Antonio (210) 244-1779 Corpus (361) 980-2002 Dr. Eduardo L. Aquino

Referring physician or associate _____

_____ The name of the physician who will perform the abortion

_____ The particular medical risk associated with the particular abortion procedure to be employed; including when medically accurate;

_____ The risk of infection and hemorrhage

_____ The potential danger to subsequent pregnancy and of infertility; and

_____ The possibility (0 % chance) of increased risk of breast cancer following an induced abortion and the natural protective effect of a complete pregnancy in avoiding breast cancer

_____ The probable gestational age of the unborn child at the time the abortion is performed.

_____ The medical risks associated with carrying the child to term.

The physician who is to perform the abortion or the physician's agent has informed me that:

_____ Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care

_____ The father is liable for assistance in the support of the child without regard to whether the father has offered to pay for the abortion.

_____ Public and private agencies provided pregnancy prevention counseling and medical referrals for obtaining pregnancy prevention medications or devices

I have also been informed of:

I have the right to review the printed materials prepared by Texas Department of Health

(TDH) Entitled "A Woman's Right to Know" booklet and the resource directory, which Describes the unborn child and a list of agencies that offer alternatives to abortion, and that those materials must be given to me if I choose to view them;

"A Woman's Right to Know" booklet and resource directory are also accessible via website

Sponsored by TDH @ <http://www.dshs.state.tx.us/wrtk/default.shtm>.

The new/updated patients rights were provided to me in writing (located in information binder)

and displayed in clinic lobby;

Alamo Women's Clinic/Coastal Birth Control Center provided me with a toll-free telephone number 1-800-973-0022 and Clinic license number 007264 or Corpus 007795 in writing to access information about the abortion clinic.

I made the following choice (choose one):

I requested and was provided a printed copy of "A Woman's Right to Know" booklet

and the resource directory.

I choose to review the "A Woman's Right to Know" material on the website.

I declined the informational material.

Patient Signature

Patient's Printed Name

Parent/Legal Guardian's Signature

Dr. Eduardo L. Aquino or attending physician

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Staff Verification (name and title): _____

PATIENT ULTRASOUND PREPARATION & INFORMATION SHEET

TRANSVAGINAL ULTRASOUND

5 weeks – 11.5 weeks *gestation*

If your pregnancy is between 5 wks – 11.5 wks, a **transvaginal ultrasound** will be performed to determine the size (growth) of the pregnancy. A device (transducer/probe) will be properly lubricated and inserted approximately 2-3½ inches vaginally. An ultrasound picture will then be recorded for your medical record (chart). At this stage of your pregnancy, a **transvaginal ultrasound** will give a more accurate measurement versus an abdominal ultrasound. You must have an empty bladder before the ultrasound is conducted; leave a *urine sample* per staff request. When you arrive to the examining room, please undress from the waist down (undergarments also), take a seat on the exam table and drape yourself (waist) with the provided white drape. A nurse and/or physician will be with you momentarily.

ABDOMINAL ULTRASOUND

12 weeks – 16 weeks *gestation*

If your pregnancy is between 12 wks – 16 wks, an **abdominal ultrasound** will be performed to determine the size (growth) of the pregnancy. A device (transducer) will be properly lubricated and then moved around the lower to mid abdominal area; abdominal ultrasounds can sometimes be a timely process. An ultrasound picture will then be recorded for your medical record (chart). You must have a full bladder for the ultrasound; a *urine sample* can be left afterwards. When you arrive to the examining room please lower your clothing down past your pubic area (do not undress, unless advised by staff). Take a seat on the exam table and drape yourself (waist) with the provided white drape. A nurse and/or physician will be with you momentarily.

Note: Your ultrasound being performed is to determine gestational growth ONLY; no medical diagnosis will be determined unless authorized by attending physician for referrals. A physician and/or trained medical staff person will perform your ultrasound. There can be discrepancy of gestational size (ultrasound measurement) from your menstrual cycle, calculation of gestational growth by greater or less than two weeks, previous ultrasounds (other facilities), digital pelvic performed by a physician, and other methods of calculating gestational size.

REQUEST FOR ULTRASOUND EXAMINATION

Date: _____

Patient Name: _____

Date of Birth: _____

I understand that a diagnostic ultrasound is a procedure that enables the clinician to view my pregnancy in order to determine the age of the fetus and to look at other structures in my uterus. This is done with an instrument that sends sound waves through the amniotic fluid (water bag).

I understand that this ultrasound is being done only to determine the age of the fetus and not abnormalities of my pregnancy, fetus, or reproductive tract. More extensive studies may be needed to diagnose specific conditions or abnormalities in the pregnancy. If more extensive studies are needed, I understand that I will be referred to a specialist for further testing. I also understand there are limitations to all imaging techniques.

While there is no evidence at present to prove negative effects of ultrasound on a developing fetus, I am aware there may be unrecognized risk with long-term exposure in any procedure.

I have read and understand the above information.

I release the attending physician and his trained medical staff from any liability arising out of or connected with this procedure, and particularly with regard to any abnormalities of my pregnancy, fetus, or reproducing tract that have not been evaluated by this study.

I hereby request that the physician and/or trained medical staff authorized by the attending physician and/or Medical Director to perform an ultrasound screening on me for the sole purpose to determining the age of the fetus.

Signature of Patient Date

Signature of Parent Date

STAFF WITNESS: _____

INFORMED SEDATION CONSENT

() INTRAVENOUS () ORAL SEDATION () DECLINED

It helps to be comfortable and calm when undergoing certain kinds of medical procedures. This can be done through the administration of intravenous sedation or oral medication. Please inform the attending physician if you have consumed any alcohol immediately prior to this appointment. Also, please tell us of any medications you are taking: prescription, over-the-counter or herbals. We also need to know if you are presently nursing.

How is it done?

A thin needle is placed in a vein in your hand or arm. The needle is attached to an intravenous tube through which medication will be given to help you relax and make you more comfortable.

You will not be asleep!

By having conscious minimal or moderate sedation, you could have less anxiety, discomfort and pain.

Before the procedure

Please wear comfortable, loose fitting clothing with short sleeves.

Prior to your appointment do not eat or drink after midnight.

It is normal to be drowsy after the procedure. For your safety, bring someone with you who can take you home afterwards.

After the procedure

You must have someone accompany you home.

Do not drink any alcoholic beverages after your treatment.

Do not drive or operate machinery or power tools for the rest of the day.

Do not make any important legal or personal decisions until the next day.

You may feel tired after the procedure, therefore, don't schedule any activities, JUST REST.

Allergic and/or other complications

Reactions to the medications used are rare, but can occur. Make sure you call the clinic if at anytime during or after the procedure you feel something is not quite right. Other complications include, but are not limited to, hematoma, infiltration outside the vein, venospasm, phlebothrombosis, intra-arterial injections and missed vein, nausea, vomiting, heart attack, stroke, brain damage or death.

I Certify: I have read and understand the above risks and benefits of conscious sedation and have had all questions answered and do hereby consent to the above sedation and will not hold Alamo Women's Clinic or Coastal Birth Control Center responsible for any unforeseen reaction to the medications.

_____/_____
Patient Signature Date

_____/_____
Parent/Guardian Signature Date

_____/_____
Staff Witness Date

_____/_____
Physician Signature Date

Surgical Post-Operative Home Care Sheet

The following post-operative care sheet will help you care for yourself at home after a surgical termination of pregnancy. We are always happy to help, if you have any questions, concerns, and / or problems, please call us at (210) 614-4742, or (361) 888-7972. If you are calling with medical questions and / or concerns, please ask to speak with a licensed nurse or attending physician.

After a surgical termination of pregnancy, you may experience the following:

Fever

Take your temperature by mouth twice a day for the next week. You may experience a low-grade fever after an abortion, this is considered normal. Be sure to take your temperature before taking any medications such as Acetaminophen (Tylenol) or Ibuprofen (Motrin) and / or a warm beverage or food. A normal temperature is 98.6 F – 100.0 F. If your temperature exceeds 100.3 F after taking a fever reduction medication please call our office as soon as possible.

Bleeding/Cramping

It is normal to have vaginal bleeding and abdominal cramping after a surgical abortion procedure. The vaginal bleeding may be different from your usual menstrual bleeding. *The bleeding you experience after an abortion is not your period.* Don't be alarmed if there is no bleeding afterwards. **DO NOT** douche, take tub baths (standup showers ONLY), use tampons, or have sexual intercourse until the physician has cleared you on your two week follow-up visit. Normal bleeding can be any of the following:

NO bleeding

Spotting (can persist up to 4 weeks)

Heavy flow for a few days

Bleeding that stops and starts up again

Blood clots can range in size from a *dime* to a *half an apple*. The blood clots may alarm you but they are considered normal.

Please call our office as soon as possible if you're experiencing *abnormal bleeding*. Abnormal bleeding can be described by soaking (totally saturated) two or more maxi pads (overnight pad, NOT panty liner) per hour for more than 2 1/2 hours at the same heavy flow. If this type of bleeding lasts more than 2 1/2 hours, please call our office immediately.

Cramping is common as your uterus is contracting to reduce to its normal size post procedure. Cramping can range anywhere from mild cramping similar to what you may experience during your menstrual cycles up to more intense cramping.

Heavy bleeding and increased cramping may occur if you engage in strenuous activities, exercising and/or lifting heavy objects (maximum 7lbs) too soon after the abortion.

To help relieve some of the post-operative discomfort, you may take 2 extra-strength Tylenol or up to 800 mg of Motrin every 4 to 6 hours. For more intensive you may take 2 extra-strength Tylenol with 3 Aleve every 4 to 6 hours. Emetrol Syrup, which is sold over the counter at your local pharmacy, may be taken for nausea or vomiting (take as directed on bottle).

Two Week Follow-Up

It is very important that you return for your two week follow-up after a surgical termination of pregnancy. For your follow-up, you will be examined by a transvaginal ultrasound. The follow-up visit is to confirm that the surgical procedure was successful and that you are not having any complications. At this time you may discuss birth control options (family planning). We are happy to start you out with a free sample of birth control (oral contraception / pill) on your two week visit.

Emergencies

If you believe that you are experiencing an emergency, please call our office first if possible, we have a 24 hour emergency exchange (210) 614-4742 for San Antonio patients, or (361) 888-7972, for Corpus Christi patients. An on-call physician or licensed nurse will return your call immediately. When calling the emergency exchange, it is most helpful if you (the patient) call rather than a friend or family member. This will speed up the emergent call back process. If your emergency is life threatening, please call **911** (ambulance) or go to the nearest emergency room immediately. If a complication occurs that can be treated in-office, there will be no additional charge. If you are experiencing any of the following problems, please call As Soon As Possible:

Temperature of 100.3 F or more after medication treatment of a fever reducer.

Abnormal bleeding (refer to bleeding section).

Severe abnormal pain or cramping after taking advised pain medication.

Rash, hives, and / or trouble breathing after taking prescribed antibiotics.

Anything you believe to be an emergency and / or questions or concerns that a physician should be aware of.

Patient Signature

Date

Parent Signature

Date

Staff Witness

Date

RECOVERY ROOM RECORD

NAME: _____ D.O.B. _____ PROCEDURE DATE _____

VITAL SIGNS

TIME BP PULSE RR SAQ2 _____

BLEEDING

CRAMPING

Light Moderate Heavy Mild Moderate Severe

EMESIS

TIME CC/ML _____

MENTAL STATUS (For moderate sedation only)

Monitoring Pt. level of consciousness

Plan of Care Monitor Medicate

Pt. oriented: x1 x2 x3

Physician /RN Signature _____

MEDICATION ADMINISTERED DOSE ROUTE TIME NURSE INITIAL

MEDICATION ADMINISTERED	DOSE	ROUTE	TIME	NURSE INITIAL
Acetaminophen	1000mg/2 tab	PO	_____	_____
Ibuprofen	800mg/1 tab	PO	_____	_____
Naproxen NA	550mg/1 tab	PO	_____	_____
Tigan	100mg/1 ml	IM	_____	_____
Demerol	100mg/1 ml	IM	_____	_____

CONTRACEPTION _____ cycles of _____ 28 days given.

Fact sheet on oral contraception reviewed and given to the patient. **NURSE INITIAL** _____

SNACKS PROVIDED

20 oz. cup of water 20 oz. cup of juice Cookies Crackers

NURSES NOTES:

Nurse Signature _____

DISCHARGE

Patient and/or chaperone (responsible party) was given verbal and written instructions by recovery room nurse of take home medications

TAKEHOME MEDICATION

AMOXICILLIN 500 mg (#9) (#6)

DOXYCYCLINE 100mg (#6)

FLAGYL 500mg (#9)

Patient receiving Flagyl 500 mg for their take home medication was provided with additional literature on Vaginal Infections and Common STD's.

Patient voided & changed sanitary napkin before D/C.

PAIN Rx PROVIDED BY MD Rx MEDICATION NAME _____

VITAL SIGN TIME BP PULSE RR SAQ2 _____

BLEEDING

CRAMPING

Light Moderate Heavy

Mild Moderate Severe

General condition: Stable Lethargic Left AMA Other:

Pt. lethargic continue monitoring Pt. stable, IV Dc'd, ready for discharge MD Signature _____

Patient accompanied by: _____

Post-op Instructions and Take Home Medications reviewed and Discharge completed by Licensed Nurse

(RN/LVN): Signature/Date/Time _____

I have received verbal and written post-operative instructions and emergency information. I do understand that my recovery room duration will be a minimum of twenty minutes or longer.

Patient's Signature

Date

PATIENT RIGHTS AT THE CLINIC

A licensed abortion facility shall ensure that all patients:

- Be allowed to make her own choice and self-determination;
 - Are ensured the right to personal privacy and confidentiality of her choices and decisions;
 - Are ensured the right to voluntary and informed consent as defined in Health and Safety Code (HSC), 171.02, without paying a fee for the informational materials;
 - Are ensured individual counseling concerning private medical information and to be given a private opportunity to ask questions;
 - Be allowed to view their medical record, including the sonogram, if one has been performed, at any time as provided by law;
 - Have access to care and treatment consistent with available resources and generally accepted standards regardless of race, creed, and nation origin;
 - Are allowed to ask additional questions after giving consent and to withdraw consent while still medically safe to do so;
 - Are provided freedom from abuse, neglect, or exploitation as those terms are defined in 1.204 of this title (relating to abuse, neglect, or exploitation defined);
 - Be allowed to review the department's informational materials as described in HSC, 171.014 and 171.015.
- You have the right to access certain information concerning this abortion facility by using the toll free telephone number listed below. If you make a call to the number your identity will remain anonymous.
- Toll Free Number: 1-888-973-0022 License Number: (San Antonio) 007264
Toll Free Number: 1-888-973-0022 License Number: (Corpus Christi) 007795

The toll free telephone line can provide you with the following information:

- Whether this abortion facility is licensed by the Texas Department of Health (TDH)
- The date of the last inspection of this facility by TDH and any violations of law or rules discovered during the inspection that may pose a health risk to you
- Any relevant fine, penalty, or judgment rendered against this facility or a doctor who provides services at this facility.

To access more information on the procedures you may do the following (optional):

- To listen to a recording by Dr. Aquino regarding required vital information about abortion procedures medical and surgical call (210) 244-1779 or (361) 980-2002.
- Via website www.dshs.state.tx.us/wrtk/default/shtm or at our clinic-"Women's Right to Know" booklet information.

Pregnancy, Parenting and Emotional Distress Resource List

This list contains the names and addresses of professional organizations that can help you find a local resource that meets your needs. There are also some toll-free assistance phone lines. The list will be updated regularly. If you do not see an organization on this list that you feel comfortable contacting, we encourage you to check with your health care provider or a clergy member as her or she may be able to give you some ideas as well.

Health & Human Services Commission

Information & Referral Information
www.hhsc.state.tx.us/tirn.tirnhome.htm

Texas Department of State Health Services

Family Health Services, Information & Referral Line
Phone: 1-800-422-2956
www.dshs.state.tx.us

Bexar County Resources:

Alamo Area Home Counseling Services
PO Box 500064
San Antonio, TX 78280
(210) 521-6392

Alpha Omega In Home Services
4538 Centerview Dr., Ste. 218
San Antonio, TX 78228
Toll-Free 1-866-730-2674
www.alphaomegainhomecounseling.com

Avalon Social Services
3707 N. St. Mary's
San Antonio, TX 78212
(210) 735-7275

Benita Family Center
4650 Eldridge Ave.
San Antonio, TX 78237
(210) 433-9300

Ecumenical Center for Religion & Health
8310 Ewing Halsell
San Antonio, TX 78258
(210) 616-0885

Postpartum Resource Center of Texas

811 Nueces
Austin, TX 78701 (1-877-472-1002-toll-free)
www.texaspostpartum.org

Toll-Free Telephone Assistance Lines:

Texas Department of State Health Services
Family Health Services, Information Line
1-800-422-2956

Nueces County Resources:

Nueces County MHMR Community Center
102 North 4th Street
Robstown, TX 78380
(361)387-3588 or Crisis Line (361) 814-8633

Dr. Carlos Estrada, MD
6625 Wooldridge Rd.
Corpus Christi, TX 78414
(361) 993-8358
(Post-procedural Psychological Counseling)

Family Outreach Of Corpus Christi
1444 Baldwin Blvd.
Corpus Christi, TX 78404
(361) 888-6041

Family Counseling Service
3833 S. Staples Ste. 203
Corpus Christi, TX 78411
(361) 852-966

Genetic Screening/ Counseling
7121 SPID Ste 202
Corpus Christi, TX 78412
(361) 985-6600

Alamo Women's Clinic
8600 Wurzbach #900E
San Antonio, Texas 78240

Coastal Birth Control Center
1901 Morgan Avenue
Corpus Christi, Texas 78404

Family Life Center
One Camino Santa Maria
San Antonio, TX 78228
(210) 302-6920

Nueces County Health Department
1702 Horne Rd
Corpus Christi, TX 78416
(361) 851-7239

Family Service Association
230 Pereida
San Antonio, TX 78228
(210) 226-3391

Women's Shelter of Corpus Christi
813 Buford St.
Corpus Christi, TX 78463
(361) 881-8888

Jewish Family & Children's Services
12500 NW Military Hwy
San Antonio, TX 78231
(210) 302-6920

Women Infant & Children's Clinic (WIC)
3455 S. Alameda
Corpus Christi, TX 78411
(361) 694-6767

Mental Health Association of Greater San Antonio
8431 Fredericksburg Rd. Suite 110
San Antonio, TX
(210) 614-7566
healthymindconnection.org

Mexican American Unity Council
2300 W. Commerce, Ste 200
San Antonio, TX 78231
(210) 978-0500

Methodist Women's Center
803 Castroville, Ste. 131
San Antonio, TX 78207
(210) 575-0355

St. Peters St. Joseph
919 Mission Rd
San Antonio, TX 78210
(210) 533-6545

Postpartum Depression Center of San Antonio
921 Proton
San Antonio, TX 78258
(210) 490-4540