DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-40117 (Rev. 02/2016)

STATE OF WISCONSIN
Wisconsin Statute Chapter 253
Effective Date: February 1, 2016

ABORTION INFORMATION PROVISION CERTIFICATION

General Information and Instructions:

Wisconsin Statute 253.10(3) requires that a physician explain certain things to you at least 24 hours before you receive an abortion except in the case of a medical emergency or if the pregnancy is the result of a sexual assault or incest. The physician must supply you with all the information below, unless he/she determines a particular item of information would cause a significant, non-temporary threat of severe harm to your mental health. The law also requires that you voluntarily agree to an abortion in writing and that you complete this form.

For each statement below, check the box by the statement if you agree that the information was provided to you.

The physician who is to perform or induce the abortion is:

_____

(To be filled in by the physician who is to perform, or induce, the abortion, or by a qualified person assisting the physician.)

I. Informed Consent

_____ *(insert name of physician)*

orally informed me, in person, on _____ *(insert date),* at _____ a.m./p.m., of the following:

☐ 1. According to my physician's reasonable medical judgment, I am pregnant and the probable gestational age of the fetus, on this date, is _____ weeks. The numerical odds of survival for an unborn child delivered at that probable gestational age are _____. This information was also provided to me in writing.

☐ 2. The probable anatomical and physiological characteristic of the fetus on this date.

☐ 3. The particular medical risks, if any, associated with my pregnancy.

☐ 4. The details of the medical or surgical method that would be used in performing or inducing an abortion.

☐ 5. The medical risks associated with the particular abortion procedure that would be used, including the risk of infection, psychological trauma, hemorrhage, endometritis, perforated uterus, incomplete abortion, failed abortion, or danger to subsequent pregnancies and infertility.

☐ 6. The recommended general medical instructions to follow an abortion to enhance safe recovery and the name and telephone number of a physician to call if complications arise.

Physician's telephone number: _____ *(To be filled in by the provider.)*

☐ 7. If, in the reasonable medical judgment of my physician, the fetus has reached viability, that the physician who is to perform or induce the abortion is required to take all steps necessary under law to preserve the life and health of the fetus.

☐ 8. That I have the right to withdraw consent, cancel the appointment, or not show for the appointment at any time before the procedure is performed.

☐ 9. That no payment for the procedure may be required from me until at least 24 hours have elapsed after the informed consent consultation has been completed, except if the waiting period is shortened by me because the pregnancy is the result of sexual assault or incest or medical emergency.

☐ 10. A list of providers that would perform the required ultrasound at no cost to me.

II. Available Services and Information (*Skip items 1-3 below if the fetus has a diagnosis of a lethal anomaly.)*

_____
(insert name of physician who is to perform, or induce, the abortion, or by a qualified person assisting the physician or other qualified physician) orally informed me, in person, on _____(insert date), at _____ a.m./p.m. of the following:

☐ 1. That benefits may be available to me under the Wisconsin Medicaid or BadgerCare Plus Program to pay for prenatal care, childbirth and neonatal care.

☐ 2. That the man responsible for pregnancy is liable for providing assistance in supporting my child, if born, even if he has offered to pay for the abortion.

☐ 3. That I have the legal right to terminate my pregnancy or to continue my pregnancy and to keep the child; to place the child in a foster home for six months; to petition the court to place the child in a foster home or group home or with a relative; or to place the child for adoption under a process that involves court approval both of the voluntary termination of parental rights and of the adoption.

☐ 4. That I have the right to receive and review, free of charge, state-printed materials that describe the unborn child and list agencies that offer alternatives to abortion.

☐ 5. That, if I have received a diagnosis of a disability for the fetus, I have the right to receive and review free of charge, information on community-based services and financial assistance programs for children with disabilities and their families, support groups for people with disabilities and parents of children with disabilities, and adoption of children with special needs.

☐ 6. That I have the right to receive and review, free of charge, information on the availability of public and private agencies and services that provide birth control information including natural family planning information; information on services available for victims or individuals at risk of domestic abuse; information about legal protections for me and my child should I wish to oppose establishment of paternity or to terminate the father's parental rights; and information on the availability of perinatal hospice.

The information listed in items 5 and 6 (above) is available through a toll free telephone number, 1-877-855-7296, and in state-printed materials, which are available through this facility.

III. Obstetric Ultrasound Performed at this Facility (*If the ultrasound was conducted elsewhere skip this section and go to section IV.*)

_____
(insert name of physician or qualified person who performed the ultrasound)

On _____ *(insert date)*, at _____ a.m./p.m., carried out the following:

☐ 1. Performed an obstetric ultrasound using the transducer I chose, after available options were explained to me.

☐ 2. Provided me an oral explanation during the ultrasound of what it depicted, including the presence and location of the fetus within the uterus, the number of fetuses, and the occurrence of the death of a fetus, if such a death had occurred.

☐ 3. Displayed the ultrasound images so that I could view them, but did not require that I do so.

☐ 4 Provided me a medical description of the ultrasound images, including the dimensions of the fetus and a description of any external features and internal organs present and viewable on the image.

☐ 5. Provided me the means to visualize a fetal heartbeat, but did not require that I do so, if a heartbeat was detectable by the ultrasound type I chose, and provided me, in a manner understandable to a layperson, a simultaneous oral explanation.

IV. Obstetric Ultrasound Performed at a Different Facility (*If you completed section III above, skip this section.)*

On _____ (insert date), at _____ (insert name of facility), at

_____(insert facility city/state), an obstetric ultrasound was performed.

☐ 1. I have provided a certificate signed by the physician who performed, or arranged for the performance of, my obstetric ultrasound that the requirements specified in section III above were carried out.

V. Obstetric Ultrasound Waiver

☐ 1**.** I have chosen to waive the performance of an obstetric ultrasound because my pregnancy is the result of a sexual assault that I reported to law enforcement authorities.

VI. Patient Certification

I certify that all of the above information was provided in an individual setting that protected my privacy, maintained the confidentiality of my decision, and ensured that the information focused on my individual circumstances but that it did not prevent me from having a person of my choice present. I certify that I was allowed adequate opportunity to ask questions and all my questions were answered in a satisfactory manner. I certify that the printed materials were physically given to me and that any visual materials were made available to me.

_____ _____

SIGNATURE - Patient Date Signed

_____ _____

SIGNATURE - Parent, guardian legal custodian, adult family member, foster parent or treatment foster parent, if applicable, for a minor Date Signed

_____ _____

SIGNATURE – Guardian of patient who has been adjudicated incompetent (if applicable) Date Signed

This form is to be placed in the patient's medical records and a copy provided to the patient.