CABBAGETOWN
WOMEN'S CLINIC

1624 Queen Street East, Unit 1,
Toronto, ON M4L 1G3
Tel: (416) 323-0642 / 1-800-399-1592
Fax (416) 323-3099

Date: _____
Time: _____
File #: _____

Last name: _____

First name: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Confidential phone #'s Cell: _____ Home: _____

Email Address: _____ Occupation: _____

Date of birth: Day_____Month_____Year_____ Current age: _____ Marital Status _____

Emergency contact Person: _____ Contact person's cell number: _____

Contact person's relationship to patient: _____

Family Doctor : _____ Telephone #: _____

How do you plan to go home today?

TTC/GO transit/Uber/Taxi/Airplane/Walking (alone / with a friend or family member) _____ is driving you home.

OPTIONAL DEMOGRAPHIC INFORMATION FOR DATA COLLECTION ONLY:

** the following information is solely for the purpose of Quality Improvement Data collection and you **do no have** to complete**

Gender:	Female / Male / Non-binary/Other: _____
Sexual Orientation:	Heterosexual/Homosexual/Bisexual/Other: _____
Ethnicity:	White-Caucasian/ Black-African American/East Asian/Aboriginal/Other: _____
Income bracket (yearly):	<50 000/ 50 001 - 100 000/ 100 001 – 200 000/ >200 000

OFFICE USE ONLY:

Medicare Ontario ☐ Other Province ☐ No Coverage ☐ IVR Code _____

Ontario Health Card #: _____ Version Code: _____

Name as seen on the health card: _____

Expiry date: _____

New Version Code: _____ Effective Date: _____ Expiry date: _____

Patient Health History:

- List any **allergies** to medications _____
- List the medications that you are currently taking and the reason: _____

_____

- Are you taking any blood thinning medications? **Y / N**
- Have you taken any street drugs in the past 48hrs? **Y/N** Which ones? _____
- Do you smoke cigarettes? **Y / N** How many/day? _____ How long? _____

Put a ✓ beside the conditions that you have or had:

☐ High Blood Pressure	☐ Heart Disease/ Arrhythmia/ Murmur	☐ Blood Clots or Varicose Veins	☐ Bleeding Disorders
☐ Anemia	☐ Sickle Cell Anemia/ Trait	☐ Malignant Hyperthermia	☐ Diabetes (I/II)
☐ Thyroid Disease	☐ Asthma	☐ Respiratory Problems	☐ Tuberculosis
☐ Epilepsy	☐ Fainting Spells	☐ Hepatitis	☐ HIV
☐ Aids	☐ Vaginal Infection	☐ Herpes	☐ Gonorrhea
☐ Syphilis	☐ Chlamydia	☐ Genital Warts	☐ Ovarian Cysts/ Tumors
☐ Fibroids	☐ Breast Lumps	☐ Migraine Headaches	☐ Kidney Disease
☐ Liver Disease	☐ Bowel Disorders		

Have you had any surgeries? **Y / N.** Please list;

_____

Is there a history of heart disease, high blood pressure, diabetes or any inherited diseases in your family? **Y / N**

Reproductive and Menstrual History: (Please CIRCLE the answer for Y or N)

- When was the first day of your last normal menstrual cycle? _____
- Are your cycles regular? **Y / N.** Do you experience cramping with your cycle? **Y / N**
  How severe are they? **Mild/moderate/severe/rare/occasional.**
- Do you have **heavy/moderate/light bleeding** with your cycle?
- Have you ever had a PAP test? **Y / N.** Have the results ever been abnormal? **Y / N.**
- Have you had an internal vaginal exam? **Y / N.**
- How many times have you been pregnant? _____ Twins? **Y / N** Miscarriages? **Y / N #**_____
- Have you had an abortion before? **Y / N.** **Surgical or medical (pills)?** How many? _____
- **How many children have you delivered?** _____ **List the ages of your children.** _____
- Are you currently breastfeeding? **Y / N.**
- Have you ever had a C-section? **Y / N.** How many? _____ **Emergent or planned** C-section?
- Have you had an ectopic pregnancy? **Y / N** How many? _____

History of current pregnancy

- Are you here for: Abortion **Y / N**? (Surgical **Y / N**? OR Medical "pills" **Y / N**? Undecided **Y / N**?), Miscarriage (D&C) **Y / N**? Genetic anomaly **Y / N**? Was this a planned pregnancy? **Y / N**
- Are you clear about your decision to terminate this pregnancy? **YES / NO / UNSURE**
- Are you experiencing any of the following? **Nausea/vomiting/breast tenderness/cramping/bleeding**
- What type of pregnancy test did you have/do? **Urine / blood test / ultrasound / none.**
  Date:_____ **U/S Result:** _____ **weeks** _____ **days**

Contraceptive History:

- Which form of birth control methods have you or are you currently using?
  Oral contraceptives / IUD / Depo Provera / Nuvaring / Ortho Evra-Patch / Condoms / Spermicides / Withdrawal / Rhythm / Nothing
- Have you experienced any problems with these methods? **Y / N**
- Do you wish to have contraceptive options reviewed? **Y / N**
  Contraceptive pills /I UD / Ortho Evra-patch / Nuvaring / Tubal ligation?
- Do you currently have an IUD in place? **Y / N**

History of Sedation or Anaesthetic

- Any previous experience with sedation? **Y / N.** Did you have any complications with sedation? **Y / N**
  Please explain

  _____

- **Circle** if you have any of the following:

  Heart disease / heart arrhythmia / asthma / chest infection/problems with your neck or jaw / sleep apnea /loose teeth/dental devices

The counsellor and nurses will explain and perform the following with the patient:

- The risks and complications related to the surgical procedures performed during the first trimester 4-12 weeks (D&C) and second trimester (D&E) abortion processes.
- The medical abortion (pills) process (4-10 weeks gestation)
- The possible need for a High-Tech Ultrasound.
- Medications, how they will be administered and why/what you may expect.
- Perform pre-operative assessment tests: Hemoglobin level, RH Factor, urine sample and baseline vital signs.
- Post-operative care/discharge, follow up appointments and contraception methods.
- Perform blood test (BHCG) to confirm pregnancy and/or completion of termination.

Are you able to make an appointment with your family Dr for a follow up? **Y / N**

Would you like to have a follow up appointment at Cabbagetown Women's Clinic? **Y / N**

**** The patient and their accompanying adult are instructed to notify Cabbagetown Women's Clinic of any unexpected admission to a hospital within 10 days of this procedure.**

I hereby declare that I have completed this form fully and truthfully to the best of my ability.

Signature of Patient: _____ **Date:** _____

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Consent for Laminaria, Digoxin and Misoprostol Administration

Laminaria is made from a dried seaweed base and resembles a tiny stick in appearance, measuring approximately 2-3 inches in length and 1/8 inch in diameter. Laminaria is used to dilate the cervix over a 24-hour period. To ensure minimal discomfort, the Doctor will administer a local anesthetic to the cervix before inserting one or more laminaria. The laminaria will then swell, absorbing moisture from the surrounding tissues and therefore dilating the cervix. The laminaria will be left in the cervix overnight. If required, this process will be repeated the next day to ensure that the cervix is dilated enough to complete the abortion safely.

The following are the risks related to the insertion of laminaria: Allergic reaction, fever and chills, infection, breakage of the laminaria and or sliding upward of the laminaria into the uterus, tearing or perforation of the cervix.

Digoxin is a medication that aids in the extraction and decreases the amount of bleeding during the procedure. Digoxin will be administered via an intra-amniotic injection on either the first or second day of laminaria insertion. Patients will be closely monitored after injection to ensure patient safety.

The following are the risks related to the Digoxin injection: Slow heart rate, weakness, low blood pressure and the need for emergent transfer to hospital in case of maternal toxicity which can be life threatening. Severe maternal toxicity has not yet ever been reported in the history of Digoxin use.

Misoprostol is a uterotonic medication used to enhance dilation as well as to minimize post-operative bleeding. Misoprostol will be administered as required via tablet.

The following are the risks related to the use of Misoprostol: nausea, vomiting, diarrhea, chills, and/ or cramping.

If you have any of the following symptoms please contact ☐ Dr. C. Pop , ☐ Dr. A. Nayot , ☐ Dr. J. Sheiner, ☐ Dr. E. Lovett, ☐ Dr. S. Black ☐ Dr. B. Friz , ☐ Dr. Vivian Gu immediately: fever, severe cramping and or heavy bleeding.

I agree to refrain from the following while the laminaria are in place: inserting anything into my vagina, sexual intercourse, using tampons or having a bath. I agree not to take any medications, drugs or alcohol unless prescribed or authorized by Dr. Cristina Pop.

I have read and understand all of the above information. I have discussed all my questions and concerns regarding the procedure. I accept all the risks described to me and grant Dr. Cristina Pop permission to proceed with the laminaria insertion, as well as the use of Digoxin and Misoprostol as required.

Patient's Signature	Date	Witness

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RELEASE FROM RESPONSIBILITY

I, _____ hereby acknowledge that prior to the insertion of laminaria, I was informed of the risks and consequences of the laminaria being removed and further acknowledge that I was given the opportunity to change my mind about having the abortion. I acknowledge that the abortion begins with the first insertion of the laminaria, that I must return to the clinic at the time scheduled for me and that I cannot change my decision about the abortion after this point.

I hereby release Cabbagetown Women's Clinic and its staff from any responsibility for the future health of both the pregnancy and expected child should I change my mind after the insertion of the laminaria.

Signature of Patient _____

Date _____

Signature of Witness _____

Date _____

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PATIENT CONSENT FOR EMAIL COMMUNICATIONS

Attach Patient Identification label

Dear Patient:

Cabbagetown Women's Clinic may communicate with you or other hospital / medical provider using e-mails you provided, at their discretion. However, you should know that these e-mail messages are NOT encrypted, may exist indefinitely and that Cabbagetown Women's Clinic, the hospital and other medical provider cannot guarantee the security of messages sent outside the hospital/medical provider system. For this reason, e-mail should not be used to communicate certain sensitive types of information which might be harmful to you if read by an unintended recipient. You may also have other types of information that you would prefer not to have discussed in e-mail messages, which you should inform your care provider about. Do Not use e-mail to communicate emergency or urgent health matters. Go to the nearest emergency department if you have an emergency.

If you have not received a response to your e-mail within an expected time period, it is your responsibility to telephone your care provider. You should not expect a response before one business day.

The clinically relevant content of the e-mail message will be filed in your medical record. Each individual care provider has the authority to decide whether to e-mail and reserves the right to cease e-mail communication at any time, in which case you will be notified. By signing this consent form, you acknowledge that you have read and agree with these terms. If you have questions about e-mail communications with Cabbagetown Women's Clinic, the hospital or care provider to whom you are referred to, please contact them directly with the telephone number provided to you. You may at any time withdraw your consent for e-mail communication by notifying the hospital / care provider and should document this consent withdrawal on this form.

I consent and agree to:

☐ Communicate with Cabbagetown Women's Clinic, hospital or my care provider team using my e-mail:
☐ My care provider / hospital communicating with _____ using e-mail
(Name of Hospital or Care Provider)

My confidential e-mail address is: _____

Date: ____/____/_____ (dd/mm/yyyy)

_____
(Signature of patient or Substitute Decision Maker)

_____
(If Substitute Decision Maker, state relationship)

Withdrawal of Consent for Email Communication. I no longer consent to communication via e-mail.

Date: ____/____/_____ (dd/mm/yyyy)

_____
(Signature of patient or Substitute Decision Maker)

_____
(If Substitute Decision Maker, state relationship)

Disclaimer: On-call physicians and those covering patient care for other physicians are not obligated to use e-mail communication with those patients.

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TRANSLATION CONSENT FORM

Communication:

☐ I am able to understand English communication and do not need a translation.

☐ I would prefer to have a translation method to communicate with staff at the clinic. (Please indicate below which of the available translation methods you would prefer:)

- ☐ Inter-personal translation by a support person you brought with you
- ☐ Inter-personal translation by a staff member (our staff can speak Mandarin, Tagalog, Romanian, French, German)
- ☐ Computer translator app.

Patient's Name: _____ Date: _____
(PRINT) (Last) (First) dd/mm/yyyy

Patient's Signature: _____

Support Person:

I choose to have a support person present for the doctor assessment and/or the counselling. I understand that the presence of this person may bring in some risks to my care (i.e. mis-translation, mis-communication, breech of privacy, emotional harm) which CWC cannot control and I will not hold the clinic responsible for any harm that arises from the support person of my choice. I understand that CWC will trust the communication and actions of my support person. By bringing my support person into the assessment room I am consenting to release the information that will be discussed in that room with my support person.

Patient's Name: _____ Date: _____
(PRINT) (Last) (First) dd/mm/yyyy

Patient's Signature: _____