

***Time appointment***

***begins***:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DOB per ID |  | |  | | | North Office West Office | | | | | |
| Last Name per ID |  | | First Name per ID | | |  | | | MI |  | |
| Nickname &/or pronunciation tips | |  | | Date of Service |  | | Advocate |  | | |

**Limitations of Service (Step 5: 4 min)**

* Assure Women’s Center is a non-profit organization. All of our services are at no cost to you, including a urine pregnancy test, limited ultrasound (if the urine test is positive), and limited Sexually Transmitted Disease (STD) testing. We also perform a situational assessment and offer information on all pregnancy options.
* The medical services are performed under the supervision of our Medical Directors, Dr. Brian Finley and Dr. Douglas Bauer. Our Licensed Medical Staff, also under their supervision, may provide an ultrasound to determine the viability of your pregnancy as of the date your ultrasound is performed.
* By signing below, you are giving your consent for a urine pregnancy test to be performed and for the results to be verbally provided to you by our Medical Staff immediately following the completion of the test.
* Whether the pregnancy or STD test is positive or negative, you should consult with a licensed physician of your own choosing. If you do not have a physician, we will offer referrals because we do not offer prenatal care.
* The information obtained here is not intended as a substitute for professional counseling.
* All information is kept confidential except if child abuse or other mandated reporting laws apply or if we believe or hear that you are in danger of hurting yourself or others.
* Assure Women’s Center does not perform or refer for abortion, which includes not providing any information regarding your visit to assist in obtaining an abortion.
* Assure Women’s Center does not profit from your decision. We are here to be a resource of information to empower you to make the best decision.

**Permission to Contact**

*Our staff would like to make follow-up contact with you after your appointment. This communication could potentially be in regards to and thus include your Protected Health Information, all of which will be kept strictly confidential. Please note that texting, emailing, and voicemail may not be secure forms of communication.*

**I hereby give my permission to be contacted:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone |  Yes |  No |  | Primary Phone | H / W / C |
| Leave Msg |  Yes |  No |  | Alternate Phone | H / W / C |
| Text |  Yes |  No |  | Best time to call? |  |
| Email |  Yes |  No |  | Email address |  |

**When we contact you by any method, may we identify ourselves as Assure Women’s Center?**  **Yes**  **No**

*I understand as read the above and hereby authorize the staff of this office to render whatever services are necessary for my care. Further, I understand that texting, emailing, and voicemail may not be secure forms of communication and give permission to be contacted according to what is specified above.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Signature** |  | Date |  |
| Advocate’s Signature |  | Date |  |

**Situational Assessment (Step 6: 5-7 min)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address | |  | | | | | | | |
| City | |  | | | State |  | | Zip |  |
| Age |  | | Birth Date |  | Prev. Patient? | * Yes | * No | Date |  |
| Please know your answer to the next question will not affect the services that you will receive from us in any way. To help us know who we are serving – do you consider yourself to be a US Citizen or the US to be your primary home?  Yes No | | | | | | | | | |

**Education**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| School Year Completed | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 GED |
| Currently in School? | * No * Yes School Name | | | | | | | | | | |
| Occupation? |  | | | | | | | | | | |

With whom do you live?

**Marital Status**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * Single | * Married | * Separated | * Divorced | * Widowed | * Unknown |

**Ethnicity/Race**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * American Indian or Alaska Native | * Asian | * Black or African American | * Hispanic | * Native Hawaiian or Other Pacific Islander |
| * White | * Unknown | * Declined | * Other | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**How did you hear about us?**

|  |  |  |  |
| --- | --- | --- | --- |
| * Family/Friends * Repeat Patient * Drove by Center * Instagram | * Website * Internet Search * Facebook * YouTube | * Radio * School Speaker * Radio Lobo | * Television * Planned Parenthood * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Religious Background**

Are you currently active in a church or religion? Yes No

**Reason for Today’s Visit**

|  |
| --- |
|  |
|  |

**Pregnancy Test Information**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1st day of last period (LMP) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date PT taken | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  | |  | | * Home | * Positive |
|  | |  | |  | * Dr.’s Office | * Negative |

**Previous Pregnancy**

|  |  |  |
| --- | --- | --- |
| Total Pregnancies  (Not including current) |  | |
| a) Carried To Term |  | |  |  |  |  |
| Female(s) DOB | |  |  |  |  |  |
| Male(s) DOB | |  |  |  |  |  |
| Are all the children living in the home with you? | | |  |  |  |  |
| b) Miscarriages |  | |  |  |  |  |
| c) Abortions |  | |  |  |  |  |
| Have any of these (birth, miscarriage, abortion) occurred in the last 8 weeks? | | |  |  |  |  |

**Previous Abortions**

|  |  |
| --- | --- |
| Physical/Emotional Effects |  |

**Intentions and Support**

**NOTE TO ADVOCATE: If patient indicates any Post Abortion Syndrome by words or action please offer Post Abortion Syndrome class (PATH) located on PSA.**

|  |  |  |  |
| --- | --- | --- | --- |
| How do you feel about potentially being pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **If your test is positive, what are your intentions for this pregnancy?** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| *ONLY when necessary, list options* | *(Direct quote)* | | |
| \*IF patient’s wording is inconclusive, **PLEASE ASK**: | | | |
| **“What options are you considering?”** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | *(Direct quote)* | | |
| I clarified her options: | * **Yes** | * **No** |  |
| Check all that apply: | * **Abort** | * **Adopt** | * **Parent** |
| Would a pregnancy at this time cause financial stress? | * **Yes** | * **No** |  |
| What is the father’s first name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| In a relationship? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How old is he? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Does the father know that you might be pregnant?  Yes  No | | | |
| What decision would the father like you to make regarding the outcome of your pregnancy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Who would support your decision if you decide to continue your pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Who would support your decision if you decide to abort your pregnancy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Is there anyone pressuring you towards any particular choice?  Yes  No If yes, who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Towards what choice?  Abort  Adopt  Parent | | | |
| Are you involved with a person who hurts or threatens you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (*If yes, please refer patient to SAFETY PLAN on PSA form. Ask the patient if she would like to meet with a staff member to review the Safety Plan options.*) | | | |
| Did anyone come with you today?  Yes  No If so, who… | | | |
|  Boyfriend/fob  Mother  Family/friend (relationship/name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Would you like your guest in the room with you should you be offered an Ultrasound?  Yes  No  (*If guests, please explain that you will bring guests in, upon a patient’s request, once the U/S has begun and they will be asked to step out upon completion.*) | | | |

**Options Presentation (Step 7: 4 min)**

|  |  |  |
| --- | --- | --- |
| **Complete Presentation** | **Option** | **Patient’s Response** |
|  | Abortion | Accept / Decline |
|  | Adoption | Accept / Decline |
|  | Parenting | Accept / Decline |

**Little White Sheet/Patient Provides Sample (Step 8: 3-5 min)**

***Time Advocate arrives in Medical Services***:

**Abortion Vulnerability**

***Time LMS gives specimen instructions to Patient***:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PTS** | **Risk Factors** | | | | **Patient Details (Complete Applicable Lines)** | | | |
|  | Still in School - hs/college/grad (2pts) | | | |  | | | |
|  | 15 and under OR 35 and over (1pt) | | | |  | | | |
|  | Person of Influence supports abortion (2pts) | | | |  | | | |
|  | Person of Influence pressure to abort (4pts) | | | |  | | | |
|  | Previous Abortions (1pt/abortion - max 4pts) | | | |  | | | |
|  | Financial Stress (1pt) | | | |  | | | |
|  | Single (2pts) | | | |  | | | |
|  | Child living with the Patient (1pt/child - max 4pts) | | | |  | | | |
|  | Patient recently gave birth – Child 23mos or younger (2pts) | | | |  | | | |
|  | Not in relationship with FOB/Uncertain of FOB (3pts) | | | |  | | | |
|  | Intention is Abortion - \*A (7pts) | | | |  | | | |
|  | Abortion is an Option – \*AIO (4pts) | | | |  | | | |
|  |  |  | **Key:** | **Likely to Carry = 0-1** | | **Low Risk**  **= 2-5** | **High Risk**  **= 6-10** | **Most at Risk = 11+** |
| **Total** | **=** | **Abortion Vulnerability** |  | | | | | |
| Patient’s Stated Intention (from page 3) | | | | | Patient’s AVR (from page 4) | | | |
| Abort Adopt Parent | | | | | Likely Low High Most  to Carry Risk Risk at Risk | | | |

**Spiritual Discussion (Step 9: 5-7 min)**

***Time Advocate begins Spiritual***

***Discussion***:

|  |  |
| --- | --- |
| * Had a spiritual discussion | |
| * Patient states she is a Christian | |
| * I gave a complete/thorough presentation of the Gospel of Eternal Life * After spiritual discussion, patient states she believes in Christ for her Eternal Life *for the first time today* * Prayed with Patient   ***Time Advocate completes Spiritual Discussion***:   * Patient declined spiritual discussion | |
| Notes regarding spiritual discussion: |  |
|  | |
|  | |

|  |  |
| --- | --- |
| * Positive | * Negative |

**Pregnancy Test Results (Step 10)**

**Licensed Medical Staff Obtains Health History from Patient (Step 11: 10-12 min)**

|  |
| --- |
| Any previous abortions revealed to the Licensed Medical Staff? |
| Y / N If yes, how many?\_\_\_\_\_\_\_ |

**Patient Name:**

**Ultrasound (Step 12: 5-7 min)**

**To be completed by Licensed Medical Staff while patient is dressing:**

 Viable Pregnancy  Nonviable Pregnancy

 Inconclusive  Twins

 Medical Care Advised

Gestational age (weeks) (days)

EDD

*Signature of Licensed Medical Staff*

***Time ultrasound session begins***:

* Ultrasound is offered
  + Patient accepts
  + Patient declines
  + Patient is rescheduled
* Ultrasound is administered
* No Ultrasound
* Patient declined guest in U/S
* Guests joined Patient for U/S: *(list who & relationship)*

**Ultrasound Room Notes, Non-medical**

* Patient accepted/declined US pictures
* Patient looked at/declined/fetal models not offered
* Patient smiled/laughed
* Patient asked questions
* Patient commented on how far along she is
* Patient asked if everything looked okay
* Patient asked about conception dates
* Patient had no emotion/quiet
* Patient cried/tearful, appeared sad
* Patient cried/tearful, appeared happy
* Patient looked away/covered her eyes
* Patient wanted guest in the room whole time
* Patient held hands/smiled with her guest
* Patient pointed out baby to her child/guest
* Guest had no emotion/quiet/asked questions
* Guest smiled/laughed

***Time ultrasound session ends***:

**NOTE TO ADVOCATE: This decision is to be made with the Licensed Medical Staff in accordance with the Repeat US Action Plan.**

**Patient does not return if she has had 4 ultrasounds (including today) OR…**

* Likely to Carry – (EVEN IF no U/S performed)
* Low Risk – Intending to parent (EVEN IF no U/S performed)
* High Risk/Most at Risk – Planned to carry at previous appointment (EVEN IF viability not confirmed)

**Bring Patient back in one week if…**

* High Risk/Most at Risk – At first visit (PT appt)
* \*Abort/\*Abortion is an Option at this appt
* \*Abort/\*Abortion is an Option at end of previous appt

**If scheduling decision made outside of this Action Plan, Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COMPLETION OF STEPS 13 AND 14 ARE REQUIRED, REGARDLESS OF WHETHER ULTRASOUND IS PERFORMED OR NOT.**

**LMS presents Personalized Solutions Assessment Using Exit Process (Step 13: 10-12 min)**

|  |
| --- |
| Patient’s Stated Intention to the Licensed Medical Staff |
| Abort Adopt Parent |

**Advocate Exit Process (Step 14: 1-2 min)**

1. “Is there any other information you feel you need?”

Yes No

2. Exit Survey Given to Patient Yes No

***Time appointment is completed***:

**Literature Given**

|  |  |
| --- | --- |
| * *Your Options: Abortion Brochure* * *Your Options: Adoption Brochure* * *Your Options: Parenting Brochure and Parenting Class Flyer* | * *Parenting Class Flyer* * *Gospel of Eternal Life Card* * *Gospel of John* * *Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

* LMS presented the Abortion Procedures, Risks and Side Effects-Yes/No?
* Patient revealed that she has an Abortion Scheduled-Yes/No? Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Copy of PSA filed in chart

**Other Notes:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_