

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Primary Phone	_____	H / W / C
Leave Msg	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alternate Phone	_____	H / W / C
Text	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Best time to call?	_____	
Email	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 Website Radio Television
 Repeat Patient Internet Search School Speaker Planned Parenthood
 Drove by Center Facebook Radio Lobo Other _____
 Instagram YouTube

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 _____

- | | |
|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Home | <input type="checkbox"/> Positive |
| <input type="checkbox"/> Dr.'s Office | <input type="checkbox"/> 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 _____

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

Intentions and Support

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
<input type="checkbox"/>	Abortion	Accept / Decline
<input type="checkbox"/>	Adoption	Accept / Decline
<input type="checkbox"/>	Parenting	Accept / Decline

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

Time Advocate arrives in Medical Services: _____

Time LMS gives specimen instructions to Patient: _____

Abortion Vulnerability

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

<u>Patient's Stated Intention (from page 3)</u>			<u>Patient's AVR (from page 4)</u>			
Abort	Adopt	Parent	Likely to Carry	Low Risk	High Risk	Most 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
- Patient declined spiritual discussion

Time Advocate completes Spiritual Discussion: _____

Notes regarding spiritual discussion:

Pregnancy Test Results (Step 10)

- Positive
- Negative

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:

Time ultrasound session begins: _____

Ultrasound (Step 12: 5-7 min)

- 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)*

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

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: _____

