



preterm

12000 shaker boulevard  
cleveland. ohio 44120.1926

### PRETERM OUTSIDE PROVIDER CONSENT VERIFICATION

Licensed Physician: \_\_\_\_\_

Facility or Address: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Patient's date of birth: \_\_\_\_\_

The above-named outside medical provider hereby verifies the following:

On [date] \_\_\_\_\_ [time] \_\_\_\_\_, a date which is expected to be at least twenty-four (24) hours before the performance or inducement of the abortion, a physician has met with the patient named above, in person, in an individual, private setting and verbally informed the patient of the following (or, if she is hearing impaired, by other means of communication): (1) the nature and purpose of the particular abortion procedure to be used; (2) the medical risks associated with that procedure; (3) the probable gestational age of the embryo or fetus; (4) the medical risks associated with carrying the pregnancy to term; and (5) given the patient adequate opportunity to ask questions about the abortion. In addition, the outside provider verifies that it has obtained authorization and consent from the patient and/or patient's representative to send this form and any accompanying protected health information to Preterm.

\_\_\_\_\_  
Signature of Physician or Physician's Representative

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Patient Signature

Instructions to outside provider:

Please mail or fax an executed copy of this form to:

Preterm

12000 Shaker Blvd.

Cleveland, Ohio 44120-1926

FAX (216) 991-4571

PHONE (216) 991-4577