

## Manual Vacuum Aspiration (MVA) Consent Form

\_\_\_\_ I request a Manual Vacuum Aspiration (MVA), a procedure that will empty my uterus. This procedure may be used as an aspiration abortion or as treatment for a miscarriage, a failed medication abortion or for abnormal uterine bleeding.

\_\_\_\_ I understand that if I am pregnant, my three options regarding this pregnancy are parenthood, adoption, and abortion. I understand that if I am pregnant, the MVA will end my pregnancy.

\_\_\_\_ I understand that before the MVA, I may have blood tests done to check me for anemia and I will have to document my Rh type by donor card, prior blood test or a new blood test. If I am Rh negative, I will get a shot of MicRhogam.

\_\_\_\_ I understand that I might be offered 2 medications before the MVA: Ibuprofen to lessen the cramping and misoprostol to help open my cervix. I will have local anesthesia with Lidocaine injected. To the best of my knowledge, I am not allergic to Ibuprofen, Misoprostol, or Lidocaine.

\_\_\_\_ I understand that the possible complications from MVA include: incomplete emptying of my uterus, infection, bleeding, allergic reaction and perforation.

\_\_\_\_ I have read this form and have had time to think about it. I have had all of my questions answered.

\_\_\_\_ I have been given an information sheet explaining how and when to get help should a question or problem arise after the procedure.

\_\_\_\_ In the event of an unexpected complication during the MVA, I request and authorize the physician to do whatever is needed to protect my health and welfare.

\_\_\_\_ I hereby consent that \_\_\_\_\_ do the procedure “manual vacuum aspiration” for me.

**Signature of patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Clinician:** \_\_\_\_\_ **Date:** \_\_\_\_\_