ABORTION INFORMED CONSENT BROCHURE

Indiana State
Department of Health

Brochure Revised:
January 4, 2017

INTRODUCTION

Upon becoming pregnant you have multiple options. You may choose parenting, adoption, or abortion. This Abortion Informed Consent Brochure was developed by the Indiana State Department of Health (ISDH) in compliance with statutory requirements [Indiana Code (IC) 16-34-2-1.5] to help you make an informed decision. At least eighteen hours before an abortion, the physician who is to perform your abortion is required to provide you with a color copy of this brochure. This brochure must be given to you individually and in private. You must certify receipt of the brochure on the ISDH Abortion Consent State Form 55320 that will be provided to you by the physician.

This brochure is intended to provide information about abortion. The ISDH has compiled abortion information from a variety of sources. The ISDH does not endorse nor is it responsible for content cited from external sources. The ISDH does not offer medical advice. Individuals should always consult with their personal physician to discuss their health issues.

AVAILABILITY OF FETAL ULTRASOUND AND FETAL HEART TONE

Before an abortion is performed, Indiana law requires the abortion provider to perform a fetal ultrasound and fetal heart tone procedure. The provider must offer you the opportunity to view the fetal ultrasound image and hear the heart tone of the fetus if the fetal heart tone is audible [IC 16-34-2-1.1(b)]. You may refuse to view the fetal ultrasound and/or listen to the fetal heart tones.

Your physician will provide you with the ISDH Fetal Ultrasound and Heart Tone Certification Form. The purpose of this form is to document that your physician offered you the opportunity to view the fetal ultrasound image and hear the heart tone.

ISDH WEBSITE

The ISDH has a website providing terminated pregnancy (abortion) information. The site houses this Abortion Informed Consent Brochure along with links to state forms, statutes, regulations, and other online information. The direct link to the site is www.in.gov/isdh/25199.htm.

FETAL DEVELOPMENT

Indiana statute states: Human physical life begins when a human ovum is fertilized by a human sperm [IC 16-34-2-1.1(a)(1)(E)].

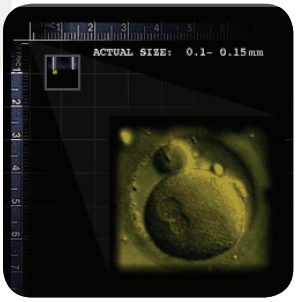
The period of time between conception and birth during which the fetus grows and develops inside the mother's uterus is called gestation. In humans, the length of pregnancy, or gestational age, is the time measured from the first day of the woman's last menstrual cycle to the current date. It is measured in weeks. Because pregnancy usually occurs during the third week of a woman's menstrual cycle, the first two weeks of gestational age actually occur before a woman is pregnant. The following information provides an overview of characteristics and changes based on estimated gestational age (EGA).

FIRST TRIMESTER

ZYGOTE PHASE

Once sperm is deposited in the vagina, it travels through the cervix and into the fallopian tubes. When a single sperm enters the mother's egg cell, the resulting cell is called a zygote. The zygote contains all of the genetic information (DNA) needed to become a baby. Half of the genetic information comes from the mother's egg and half from the father's sperm. The fertilization process takes about 24 hours.

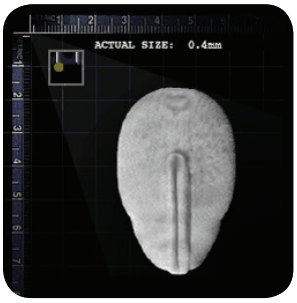
BLASTOCYST PHASE



2-3 Weeks EGA

The zygote spends the next few days traveling down the fallopian tube and divides to form a ball of cells, called a blastocyst. The blastocyst reaches the womb (uterus) around day 5 after fertilization (3 weeks EGA) and implants into the uterine wall sometime between 6-11 days after fertilization (3-4 weeks EGA).

EMBRYO PHASE



4-5 Weeks EGA

The blastocyst is now called an embryo and contains 3 layers of cells that will develop into skin, nervous system, bones, muscle, and internal organs. At this stage, the embryo forms a placenta and umbilical cord and anchors itself firmly to the uterine wall. During week 5 EGA, cells differentiate into those that will eventually form organs, and the heart and nervous system begin to form. Blood cells and blood vessels begin to form.

6 Weeks EGA

Facial features are beginning to form, with dark spots where the eyes will eventually be, openings for the nostrils, and pits which will form ears. Arm and leg buds are beginning to protrude. The brain is forming. The heart is beating regularly at about 150 beats per minute and can be seen on an ultrasound. The very earliest blood vessels are formed and blood has begun circulating.

8 Weeks EGA

The embryo measures about 0.6 inch from the top of its head to its buttocks (crown to rump length) and weighs 0.04 ounce. Crown to rump length is used to measure a baby until about week 20. The baby is then measured from head to toe. The jaw and facial muscles are developing and teeth buds are beginning to form. The pituitary gland, responsible for regulating many hormones, is beginning to develop. The trachea, or windpipe, and intestines are beginning to form. The heart now has four chambers. The diaphragm, separating the chest from the abdomen, is forming. The arms and legs have grown longer, and foot and hand areas can be distinguished.

10 Weeks EGA

The embryo measures about 1.2 inches and weighs 0.14 ounce. The head is round and more erect. The external part of the ear is well-developed. Taste buds are beginning to form on the tongue. The intestines, which originally formed in the umbilical cord, start to migrate back into the abdomen. The limbs are well-formed.

12 Weeks EGA

The embryo measures about 2.1 inches and weighs 0.5 ounce. The basic structure of the brain is complete. The face has a human appearance, and the genitalia begin to show the gender of the embryo. The eyes are now closed and will not re-open until about the 28th week. Vocal cords are formed, and the embryo begins to make sounds. The digestive tract begins to have contractions. The thyroid and pancreas are developed and the pancreas begins to secrete insulin.

SECOND TRIMESTER

FETAL PHASE

14 Weeks EGA

The fetus measures about 3.4 inches and weighs 1.5 ounces. The head is resting on a well-defined neck, and the cheeks are beginning to fill out as the sucking muscles develop. Fetal lungs continue to develop as the fetus inhales and exhales amniotic fluid. The spleen is fully functional. The fetus has visible sexual organs distinguishing female or male.

16 Weeks EGA

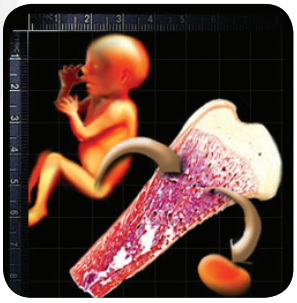
The fetus measures about 4.5 inches and weighs about 3.5 ounces. The fetal respiratory and digestive systems are more developed, and the fetus makes sucking and swallowing movements. The torso is growing rapidly. Limbs are well-developed and more defined with toenails beginning to grow from their nail beds.

18 Weeks EGA

The fetus measures about 5.6 inches and weighs 6.7 ounces. The eyes and ears are in their final position on the face. The fetus begins to develop reflexes, such as blinking. Fingerprints and toe prints develop. Fetal circulation is completely functional at this gestational age. Nerves are being insulated by a fatty substance called myelin which helps speed up the transmission of impulses. At this time the fetus begins to move actively, a feeling women often describe as “fluttering.”

20 Weeks EGA

The fetus measures about 6.6 inches and weighs 10.5 ounces. It continues to move actively, but also has phases of sleep and waking. The skin is thin and almost transparent, and fine hair (called lanugo hair) is beginning to appear on its head. Eyebrows are beginning to form. The ovaries of female fetuses contain primitive egg cells already, and the uterus is fully formed.



22 Weeks EGA

The fetus measures about 11 inches and weighs 15 ounces. The brain begins growing very rapidly, and continues this rapid growth until about 5 years of age. The fetus starts to blink more often and the heartbeat grows stronger. The testes of male fetuses begin descending from the pelvis into the scrotum. The legs approach final length and proportion relative to the body. By 23 weeks EGA, fetal bone marrow will take over the job of making blood cells, which were previously produced by the liver and spleen.

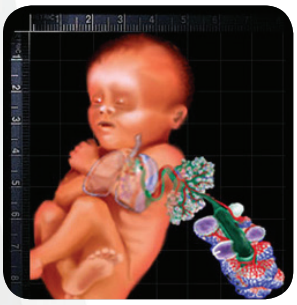
24 Weeks EGA

The fetus measures about 12 inches and weighs 1.3 pounds. The ear bones harden, so the fetus can now hear sounds. The fetus and all the internal organs continue to grow. Blood vessels, bones and organs are visible underneath the thin layer of wrinkled, translucent, skin. The fetus continues to be active.

26 Weeks EGA

The fetus measures 14 inches and weighs 1.7 pounds. Fetal brain activity increases, activating visual and auditory pathways. Blood vessels develop in the lungs, preparing the fetus to circulate oxygen throughout its body after birth. Fetal lungs, however, are not yet ready to breathe outside the womb. Fingernails and toenails continue to grow, and the fetal spine strengthens to support the increase in fetal weight.

THIRD TRIMESTER



28 Weeks EGA

The fetus measures about 14.8 inches and weighs 2.2 pounds. The fetal body is 2% to 3% fat. The brain continues to develop. The eyes are partially open and eyelashes are present. The lungs, while immature, are capable of breathing air.

30 Weeks EGA

The fetus measures about 15.7 inches and weighs 2.9 pounds. As the fetal brain grows, the surface of the brain becomes "wrinkled" to make room for more cells. The brain has begun to control the fetus's breathing and body temperature. The lanugo hair is almost entirely gone and real hair is beginning to grow on the head. As the fetus gains weight, fat is deposited under the skin, giving the skin a smoother appearance.

32 Weeks EGA

The fetus measures about 16.7 inches and weighs 3.75 pounds. As the brain continues to grow, it pushes outward on the skull, resulting in an increased head size. The fetus pulls its knees up toward its chest as it begins to outgrow the cramped uterine space.

34 Weeks EGA

The fetus measures about 17.7 inches and weighs 4.7 pounds. The eyes are open while the fetus is awake and closed during sleep. The fetus begins to develop its own immune system. The fingernails are now long enough for the fetus to scratch itself.

36 Weeks EGA

The fetus measures about 18.6 inches and weighs 5.8 pounds. Many fetuses are head-down at this stage, getting ready for birth. About 15% of fetal weight is fat to help sustain its body temperature. The elbows and knees are beginning to dimple and the neck is developing creases.

38 Weeks EGA

The fetus measures about 20 inches and weighs 6.8 pounds. It may be in a head-down position for delivery. The body is round and plump resulting from new fat stores. The fetus has developed an orienting response which causes it to turn toward light. The lungs increase their production of surfactant, which keeps the air cells open after birth to allow the newborn to breathe. Intestinal waste (Meconium) is accumulating in the intestine, and is usually eliminated after birth. Space is tight now, restricting fetal movement and requiring the fetus to draw its limbs closer to its body. Most of the bones are flexible and won't be completely hardened until after birth.

40 Weeks EGA

The fetus is considered full term at 40 weeks EGA. The total weight of the fetus will vary but, on average, a full term baby will weigh between 6 and 9 pounds. The baby's length will be about 20 or 21 inches. There may still be some lanugo hair on the upper arms and shoulders. Small breast buds are present. Head hair is now coarse and thicker. The fetus has multiple reflexes which are automatic, such as rooting behavior when its cheek is stroked.

Fetal development references: "Fetal Development." MedlinePlus, U.S. National Library of Medicine, Updated September 12, 2011. Retrieved June 30, 2013 at http://www.nlm.nih.gov/medlineplus/ency/article/002398.htm.

Fetal development and pictures of fetal development: "The Visible Embryo." National Institute of Health and National Institute of Child and Human Development from the Carnegie Collection of Human Development. Retrieved November 27, 2013, at http://www.visembryo.com/baby/index.html. Content protected under a Creative Commons License. The Visible Embryo web site is provided for general information only. The information contained on this site should not be treated as a substitute for medical, legal or other professional advice. The Visible Embryo is not responsible or liable for the contents of any websites of third parties.

"Average fetal length and weight chart." Baby Center. Retrieved January 28, 2014 at www.babycenter.com/average-fetal-length-weight-chart.

FETAL VIABILITY

Viability of a fetus means that a fetus is capable of living outside the uterus. Important factors that determine the chance of an extremely premature fetus surviving outside the uterus include:

- *Gestational age (number of completed weeks of pregnancy) at the time of birth*
- *Weight*
- *Lung maturity*
- *The presence or absence of congenital abnormalities or malformations*
- *The presence or absence of severe diseases, especially infection*

Additional factors which may impact a premature infant's chance of survival include:

- *Premature rupture of the fetal membrane before 24 weeks of gestation with loss of amniotic fluid*
- *Gender*
- *Race*
- *Maternal diabetes*

There are no definite limits regarding fetal development, age, or weight that ensure a fetus is viable outside the uterus. The chance of intact survival for an extremely premature infant born before 26 weeks of gestation is considerably lower. This table below shows the approximate chance of an infant surviving if born prematurely.

COMPLETED WEEKS OF GESTATION AT BIRTH *- using last menstrual period*	CHANCE OF SURVIVAL
21 weeks or less	0%
22 weeks	0% - 10%
23 weeks	10% - 35%
24 weeks	40% - 70%
25 weeks	50% - 80%
26 weeks	80% - 90%
27 weeks	Greater than 90%
30 weeks	Greater than 95%
34 weeks	Greater than 98%

Fetal Viability References:

1. "Fetal Viability and Death." United States National Commission for the Protection of Human Subjects of Biomedical and Behavior Research (2006-05-23). Retrieved November 17, 2013, at https://scholarworks.iupui.edu/bitstream/handle/1805/583/OS76-127_VII.pdf?sequence=1.

2. "What are the chances that my baby will survive?" Spencer's Hope, Clarksburg, MD. Retrieved October 23, 2013, at http:www.spensershope.org/chances¬_for_survival.htm.

WHAT IS ABORTION

Indiana statute states: Childbirth is preferred, encouraged, and supported over abortion [IC 16-34-1-1].

An elective abortion is a procedure that ends a pregnancy. Through an abortion procedure, drugs or surgery are used to remove the embryo or fetus and placenta from the uterus. The procedure is performed by a licensed physician. The decision to end a pregnancy is very personal. If you are thinking of having an abortion, health care providers advise talking with your spouse or partner, a trusted family member, friend or clergy, or a health care professional.

Spontaneous abortion, or miscarriage, occurs when a pregnancy ends on its own before the 20th week. It happens when problems with a pregnancy cause the woman to lose the pregnancy naturally.

Definition Reference: "Abortion." MedlinePlus, U.S. National Library of Medicine, Updated February 22, 2014. Retrieved March 5, 2014, at http://www.nlm.nih.gov/medlineplus/abortion.html.

SURGICAL ABORTION

DESCRIPTION OF SURGICAL ABORTION PROCEDURES

A surgical abortion is a procedure that ends a pregnancy by removing the fetus and placenta from the mother's womb (uterus). In Indiana, the cutoff date for surgical abortions is the earlier of viability of the fetus or twenty (20) weeks of postfertilization age. The only exception after 20 weeks is the substantial permanent impairment of the life or physical health of the mother [IC 16-34-2-1]. Surgical abortions are performed in a health care facility such as a hospital or abortion clinic. Before a surgical abortion, the doctor will examine your uterus, give you an antibiotic, offer you medicine for pain, then inject numbing medicine around the cervix (opening of the uterus). The cervix is dilated using one or more of the following: medications taken by mouth, absorbent material placed in your cervix, or mechanical dilators used at the time of the abortion.

The most common type of surgical abortion procedure is called aspiration or vacuum aspiration. Aspiration is generally used up to 16 weeks after a woman's last period. During an aspiration abortion, the doctor will use dilators to open your cervix and insert an instrument called a cannula into your uterus. Suction is then applied to remove the fetus, placenta, and membranes from the uterus.

Another type of surgical abortion is a Dilation and Curettage (D&C). D&C may be performed up to 16 weeks after a woman's last period. It is similar to a vacuum aspiration except no suction is used. After the cervix is opened, the doctor will use an instrument called a curette to scrape the walls of the uterus to remove the fetus, placenta, and membranes from it.

The last type of surgical abortion is a Dilation and Evacuation (D&E). D&E is usually performed later than 16 weeks after a woman's last period. During a D&E abortion, medical instruments and a suction machine empty your uterus. The doctor will open your cervix and then scrape your uterus to remove the fetus. It may be necessary to use forceps or other instruments to remove remaining pieces of the fetus.

After a surgical abortion, you will be monitored in a recovery area. If you have an Rh-negative blood type, you will receive a shot to protect future pregnancies. You may have cramping and bleeding after the procedure. It is also normal to have no bleeding. You may pass a few blood clots and experience heavy bleeding for a few days. You may have spotting for up to six (6) weeks. It is important to follow your physician's instructions and return for a follow-up appointment in 2 to 4 weeks.

Go to the emergency department and call the clinic or doctor that performed the abortion if you have:

- *Heavy bleeding – Passing clots larger than a lemon or soaking through two or more pads an hour for two or more hours in a row*
- *Severe pain that pain medication is not controlling*
- *Shortness of breath or chest pain*
- *Foul smelling vaginal discharge*
- *Chills and a fever of 100.4 degrees Fahrenheit or higher after the day of the abortion*
- *Nausea, vomiting, or diarrhea that lasts more than 24 hours*
- *Signs that you are still pregnant such as nausea, breast tenderness, fatigue*

RISKS OF SURGICAL ABORTION

Risks of surgical abortion include:

- *Injury to the cervix or uterus, including uterine perforation*
- *Excessive bleeding*
- *Infection of the uterus or fallopian tubes*
- *Scarring of the inside of the uterus*
- *Allergic reaction to the medicines or anesthesia*
- *Incomplete abortion with the need for another procedure*
- *Failure to end the pregnancy*
- *Undetected ectopic pregnancy*
- *Death*

Surgical Abortion Section Reference: "Surgical Abortion." MedlinePlus, U.S. National Library of Medicine, Updated November 8, 2012. Retrieved June 30, 2013, at http://www.nlm.nih.gov/medlineplus/ency/article/002912.htm.

ABORTION BY ABORTION INDUCING DRUGS

DESCRIPTION OF AN ABORTION BY ABORTION INDUCING DRUGS PROCEDURE

This type of abortion is often referred to as a medication or medical abortion. An abortion by abortion inducing drugs uses medication taken orally to end a pregnancy. The abortion pill will be given to you in a clinic or doctor's office. A second medication will be given to take later at home. You may be given antibiotics to be taken later. An abortion by abortion inducing drugs does not require anesthesia or surgery. Abortions by abortion inducing drugs end the pregnancy 97 percent of the time. Because the drugs used for the abortion are not always effective, you may still need a surgical abortion procedure to end the pregnancy.

Indiana law does not permit the use of abortion inducing drugs beyond nine weeks post-fertilization age (11 weeks EGA) unless indicated for this purpose by the Food and Drug Administration. Indiana statute states:

> *… an abortion inducing drug may not be dispensed, prescribed, administered, or otherwise given to a pregnant woman after nine (9) weeks of post-fertilization age unless the Food and Drug Administration has approved the abortion inducing drug to be used for abortions later than nine (9) weeks of post-fertilization age. A physician shall examine a pregnant woman in person before prescribing or dispensing an abortion inducing drug. As used in this subdivision, "in person" does not include the use of telehealth or telemedicine services [IC 16-34-2-1(a)(1)].*

The most common type of abortion inducing drug is called mifepristone. This is a pill that blocks progesterone, a hormone needed for pregnancy. Without progesterone, the lining of the uterus breaks down and pregnancy cannot continue. The drug mifepristone is followed in a few days by another drug, misoprostol, which causes cramps, heavy bleeding, and expulsion of the embryo.

In addition to bleeding and cramping, you may experience dizziness, nausea, diarrhea, or vomiting; feel temporary abdominal pain; or have a mild fever or chills.

It is normal to have some spotting or bleeding for up to four weeks after taking misoprostol. A follow-up appointment should be scheduled within two weeks of the medication abortion to make sure the abortion is complete and there are no complications.

CONTRAINDICATIONS

An abortion by abortion inducing drugs may not be an option if you:

- *Are too far along in your pregnancy. Indiana law does not permit the use of abortion inducing drugs after 9 weeks post-fertilization (11 weeks EGA) unless indicated for this purpose by the United States Food and Drug Administration [IC 16-34-2-1(a)(1)].*
- *Have certain medical conditions, such as uncontrolled high blood pressure, diabetes, certain heart or blood vessel diseases, severe liver, kidney or lung disease, or an uncontrolled seizure disorder.*
- *Have an allergy to the medications used.*
- *Take a blood thinner or certain steroid medications.*
- *Cannot attend follow-up visits with your health care provider or don't have access to emergency care.*
- *Have a high risk of uterine rupture. Although uterine rupture during an abortion by abortion inducing drug is rare, if you have a surgical scar that places you at increased risk for uterine rupture, you may be admitted to the hospital for observation. Intrauterine devices (IUDs) should be removed before taking abortion inducing drugs and the location of the pregnancy must be confirmed.*

Abortion Inducing Drugs Reference: "Medical Abortion." Mayo Clinic. Updated May 31, 2012. Retrieved June 30, 2013, at http://www.mayoclinic.com/health/medical-abortion/MY00819/METHOD=print.

RISKS OF ABORTION BY ABORTION INDUCING DRUGS

Risks of an abortion by abortion inducing drugs include:

- *Heavy bleeding*
- *Incomplete abortion, which may need to be followed by surgical abortion*
- *Failure to end the pregnancy, which results in the need for a surgical abortion*
- *Infection*
- *Prolonged nausea, vomiting, or diarrhea*
- *Blood clots in the uterus*
- *Death*

Abdominal discomfort, diarrhea, nausea, vomiting, or weakness more than 24 hours after taking misoprostol could be a sign of serious infection. Call your physician immediately if you have any of these symptoms.

Abortion Inducing Drug Risks Reference: "Medical Abortion." MedlinePlus, U.S. National Library of Medicine, Updated November 8, 2012. Retrieved June 30, 2013, at http://www.nlm.nih.gov/medlineplus/ency/article/007382.htm.

RISKS AND COMPLICATIONS

OVERALL RISK OF COMPLICATIONS

Complications of abortions by abortion inducing drugs performed before 9 weeks of pregnancy occur in less than 0.5% of procedures. Serious complications occurring during aspiration procedures performed before 13 weeks of pregnancy also occur in less than 0.5% of procedures.

Factors that affect the possibility of complications include:

- Overall health
- Skill and training of the physician performing the procedure
- Type of anesthesia used
- Abortion procedure used

RISKS TO A SUBSEQUENT PREGNANCY OR OF INFERTILITY AFTER ABORTION

Risks of infertility may occur if there are serious complications during or after abortion procedures. Complications of an abortion (infection, hemorrhage, injury to the cervix or uterus) may increase the risk of infertility or require surgical repair to restore fertility.

Some research on abortion and pregnancy suggests a possible link between abortion and an increased risk of:

- Vaginal bleeding during early pregnancy
- Preterm birth
- Low birth weight
- Placenta previa, a condition that occurs when the placenta partially or completely covers the cervix, which can cause severe bleeding before or during delivery.

Reference: "Abortion: Does it Affect Subsequent Pregnancies?" Mayo Clinic. August 6, 2011. Retrieved June 30, 2013, at http://www.mayoclinic.com/print/abortion/AN00633/METHOD=print.

RISK OF DEATH TO THE WOMAN AFTER AN ABORTION

Mortality risks are lower when an abortion is performed in the early weeks of pregnancy. According to the Centers for Disease Control and Prevention (CDC), during 2008 - 2012, there was one maternal death for every 153,846 legally induced abortions in the United States. The risk of death associated with abortion increases with the length of pregnancy. The risk of the woman dying from an abortion is:

- One death per one million abortions performed at 8 weeks or less
- One death per 500,000 abortions performed at 9-10 weeks
- One death per 250,000 abortions performed at 11-12 weeks
- One death per 58,823 abortions performed at 13-15 weeks
- One death per 29,411 abortions performed at 16-20 weeks
- One death per 11,236 abortions performed at 21 weeks or more

References: "Induced Abortion in the United States." Guttmacher Institute. Updated February 2014. Retrieved March 5, 2014, at www.guttmacher.org/pubs/fb_induced_abortion.html , citing, Bartlett LA et al., "Risk factors for legal induced abortion-related mortality in the United States," Obstetrics & Gynecology, 2004, 103(4): 729-737.

"Abortion Surveillance – United States, 2013." Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, November 25, 2016 / 65 (12); 1-44.

PREGNANCY RISKS

According to the Centers for Disease Control and Prevention (CDC), there was one maternal death for every 6,289 live births in 2012. Considerable racial disparities in pregnancy-related mortality exist. During 2012, the pregnancy-related mortality ratios were:

- 1 death per 8,475 live births for white women
- 1 death per 2,433 live births for black women
- 1 death per 6,369 live births for women of other races

The most common causes of pregnancy-related death in the United States during 2011-2012 were:

- Non-cardiovascular diseases, ***15.3%***
- Cardiovascular diseases, ***14.7%***
- Infection or sepsis, ***12.7%***
- Hemorrhage, ***11.3%***
- Cardiomyopathy, ***10.8%***
- Thrombolic pulmonary embolism, ***9.0%***
- Hypertensive (high blood pressure) disorders of pregnancy, ***7.6%***
- Cerebrovascular accidents, ***6.5%***
- Amniotic fluid embolism, ***5.7%***
- Complications from anesthesia, ***0.2%***

Factors that affect the possibility of complications include:

- Skill and training of the physician providing prenatal care and delivering the baby
- Type of delivery (vaginal birth versus Cesarean section)
- Overall health
- Age
- Weight
- Type of anesthesia used
- Smoking
- Drug use
- Alcohol

Reference: http://www.cdc.gov/reproductivehealth/maternalinfanthealth/PregComplications.htm#3. http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PMSS.html.

AFTER THE ABORTION

DISPOSITION OF ABORTED REMAINS

You have the right to determine the final disposition of the aborted fetus. The abortion clinic must provide for either disposition by burial in an established cemetery or cremation. At least 18 hours prior to an abortion, the clinic will provide you with information on their available method of disposition. The clinic will give you a form providing information on the disposition on the remains of an aborted fetus. Once you have decided the disposition of the remains, the clinic will have you complete another form recording your decision on disposition.

COUNSELING

Following an abortion, you may want to receive counseling to provide support. At least 18 hours prior to an abortion, the abortion clinic will provide you with a form providing information on the availability of counseling following the abortion.

SOCIAL SERVICES

MEDICAL ASSISTANCE BENEFITS

Indiana statute states: Medical assistance benefits may be available for prenatal care, childbirth, and neonatal care from the county office of the division of family resources [IC 16-34-2-1.1(a)(2)(A)].

A number of state agencies in Indiana may be able to provide medical assistance for prenatal care, childbirth, and neonatal care. The following are links to these agencies:

- Indiana Medicaid- *http://www.indianamedicaid.com*
- Hoosier Healthwise Program- *http://www.in.gov/fssa/ompp/2544.htm*
- Division of Family Resources- *http://www.in.gov/fssa/2407.htm*
- Presumptive Eligibility Program- *http://member.indianamedicaid.com/programs--benefits/medicaid-programs/presumptive-eligibility.aspx*
- Hoosier Rx- *http://www.in.gov/fssa/ompp/2669.htm*
- Partnership for Prescription Assistance- *http://www.pparx.org*

Pregnant women can make up to $23,924 in annual income and qualify for Medicaid coverage for medical care for herself and her child. These benefits almost completely cover the medical costs of the pregnancy.

RESPONSIBILITIES OF BIOLOGICAL FATHER

Indiana statute states: The father of the unborn fetus is legally required to assist in the support of the child. In the case of rape, the information required under this clause may be omitted [IC 16-34-2-1.1(a)(2)(B)].

REPORTING TO DEPARTMENT OF CHILD SERVICES

Indiana laws were adopted to protect children from child abuse. These laws require reporting of pregnancies of a female less than fifteen years of age. Indiana statute states:

> *The pregnancy of a child less than fifteen (15) years of age may constitute child abuse under Indiana law if the act included an adult and must be reported to the department of child services or the local law enforcement agency under IC 31-33-5 [IC 16-34-2-1.1(a)(1)(J)].*
>
> *… if an abortion is performed on a female who is less than fourteen (14) years of age, the physician performing the abortion shall transmit the form to the state department of health and the department of child services within three (3) days after the abortion is performed [IC 16-34-2-5(b)].*

ADOPTION

Indiana statute states: Adoption alternatives are available and adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care [IC 16-34-2-1.1(a)(2)(C)].

An adoption constitutes the act of giving your birth child to someone else to raise the child. Adoption is a permanent, legal agreement in which you give your consent to place your child in the care of another person or family.

A woman may choose open adoption, by which she selects the adoptive family and arranges the type of relationship she will have with the adoptive family. Closed (confidential) adoption is possible if the woman wants privacy.

The most common reasons a woman chooses adoption are:

- She is not ready to be a parent
- She cannot afford to raise a baby
- She feels that raising a baby now would make it too difficult to work or go to school
- She doesn't want to be a single parent
- She feels too young or too immature to raise a child
- She believes adoption is the best chance for her child to be well cared-for financially and emotionally

The cost of adoption is generally paid by the adoptive parents. Indiana law allows adoptive parents to reimburse the birth parent up to $3,000 in pregnancy-related expenses. These expenses may include medical costs, counseling, attorney fees, lost wages and living expenses during pregnancy including transportation and clothing.

LINKS TO INFORMATION ON ADOPTION

- Adoption, Indiana Department of Child Services- *http://www.in.gov/dcs/2730.htm*
- "For Expectant Parents Considering Adoption." Child Welfare Information Gateway, U.S. Department of Health and Human Services- *https://www.childwelfare.gov/topics/adoption/*
- Women's and Children's Health Information, Office of Women's Health, Indiana State Department of Health- *http://www.in.gov/isdh/18061.htm*
- Maternal and Child's Health Program, Indiana State Department of Health- *http://www.in.gov/isdh/21041.htm*
- Stronger, healthier babies, March of Dimes- *http://www.marchofdimes.com/default.html*

RELINQUISHING YOUR BABY: THE SAFE HAVEN LAW

Indiana has enacted the "safe haven" law [IC 31-34-2.5].

SAFE HAVEN HOTLINE: 1-877-796-4673 (HOPE) or Call 2-1-1.

Indiana law has made it simple to ensure the safety of your baby with no questions asked. The "safe haven" law allows you to voluntarily surrender your baby, if not more than thirty (30) days old, to an emergency medical services provider. An emergency medical services provider may be a firefighter, law enforcement officer, paramedic, emergency medical technician, physician, nurse, or other person who provides emergency medical services in the course of the person's employment. Upon surrender, the emergency medical service provider will take custody of the child and protect the child's physical health and safety. You are not obligated to give your name if you leave the child with an emergency medical services provider voluntarily and in good faith.

INDIANA 211 SERVICE

NEED HELP? Call 2-1-1.

2-1-1 is a simple way to connect to food, shelter and housing assistance, employment services, counseling resources and much more! Indiana 211 Partnership, Inc. (IN211) is a nonprofit organization dedicated to building the 2-1-1 system for Indiana. The goal is to create a seamless network of information and referral services that enable anyone in Indiana in need of human services to find quick referrals to service providers by dialing 2-1-1. Aggregate data will be collected to assist communities in assessing needs and allocating resources. Learn more about your local 2-1-1 at http://www.in211.org/.

DISCLAIMER

This Abortion Informed Consent Brochure was prepared by the Indiana State Department of Health (ISDH) as required by IC 16-41-2-1.5. This brochure was created to provide general information about abortion and should not be considered legal, medical, or other professional advice. Information contained in this brochure may not apply to your specific situation, and you are advised to consult your physician and attorney for advice specific to your situation. If you are considering an abortion, the ISDH encourages you to consult with your personal physician, spouse or partner, trusted family member, friend or clergy, or a health care professional. While the ISDH has made an effort to provide current and objective scientific information, the ISDH acknowledges that there are differing medical opinions on many issues. The ISDH does not endorse nor is it responsible for content from external sources. Content and links were based on information available at the time of the development of this brochure. There is no guarantee that the information included in this brochure is the most up to date or recent medical, legal, or professional information available.

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Indiana State Department of Health

www.in.gov/isdh

Indiana State Department of Health

2 North Meridian Street

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CONTACT AND CARE INFORMATION

Follow-up care by the physician or the physician's designee who is licensed under IC 25-22.5 is available on an appropriate and timely basis when clinically necessary. The following care and contact information is being provided by the physician who will be performing the abortion. Please keep this information accessible.

Physician Information

_____ _____

Name of Physician Performing the Abortion | Physician's Medical License Number

Emergency Contact Information

The following is an emergency telephone number where the physician or the physician's designee may be contacted twenty-four (24) hours a day, seven (7) days a week.

_____

Emergency Telephone Number