MEDICAL ABORTION CHARTING FORM

Patient Name: 
Tel: 
DOB: 
Age: 
Health Card: 

1. Counselling

☐ Pregnancy options counselling provided
☐ Surgical vs. medical abortions discussed
☐ Medical abortion protocol explained
   ☐ Reviewed timing of ultrasound, lab tests, medications, follow-up appointment
   ☐ Reviewed effectiveness, side effects and potential complications
☐ Contraception plan: __________________________________________ start date: ____ / ____ / ____

2. Determine Eligibility for a Medical Abortion

Confirm All Inclusion Criteria

☐ Expresses clear decision to have an abortion
☐ No indication of being coerced into abortion
☐ Informed consent process completed
☐ Understands expected side effects (bleeding, cramping)
☐ Agrees to comply with the visit schedule
☐ Agrees to a surgical abortion should pregnancy continue
☐ Understands when and where to consult in case of emergent complications
☐ Has access to a telephone, transportation, and emergency medical care
☐ Review of current medications
☐ Allergies: __________________________________________

Absolute Contraindications (exclude all)

☐ Chronic adrenal failure
☐ Inherited porphyria
☐ Uncontrolled asthma
☐ Allergy to mifepristone or misoprostol
☐ Ectopic pregnancy
☐ Coagulopathy or current anticoagulant therapy

Consider and Manage Relative Contraindications:

☐ Pregnancy of unknown location or gestational age
☐ Long term corticosteroid use
☐ Anemia with hemoglobin Hb < 95 g/L
☐ IUD in situ (no longer a contraindication if removed)

3. Physical Exam, Gestational Age, Pregnancy Location

☐ LMP: ____ / ____ / ____ (date)
☐ G: ____ T: ____ P: ____ A: ____ L: ____
☐ Vital signs: BP ____ HR _____
☐ Gestational age on ____ / ____ / ____ is: ____ wks ____ days
   □ confirmed clinically and with urine test OR
   □ confirmed by ultrasound
☐ βhCG done or planned [see section 4, Labs] OR
☐ βhCG not done
☐ Follow-up appointment scheduled ____ / ____ / ____ (date)

4. Initial Labs and Imaging

Lab tests completed/results:
☐ ABO RH _____ ☐ Antibody Screen _____
   □ 120 or 300 µg Rho(D) Ig given
☐ Hemoglobin _____
☐ Baseline βhCG ____ IU on ____ / ____ / ____
☐ Gonorrhea and chlamydia

Imaging
☐ Dating ultrasound requisition, appointment on ____ / ____ / ____ (date)

5. Provision of Mifegymiso®

☐ Review U/S and lab results with the patient and agree to proceed
☐ Prescribe Mifegymiso® (indicate on prescription a “dispense before” date appropriate for gestational age)
   □ Planned date for mifepristone: ____ / ____ / ____ (date)
   □ Planned date for misoprostol: ____ / ____ / ____ (date)
☐ Review how and where to take the medication, timing
☐ Review pain and bleeding management and side effects with the patient and prescribe pain medication
☐ Provide written information on follow-up, when and where to seek emergency care, and who to call for questions
☐ Other discussion ________________________________________________________________

Initial Appointment Signatures

Signature of healthcare professional providing counselling: Date: 

Signature of prescribing healthcare professional: Date: 

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### 6. Follow-up Appointment (7-14 days post mifepristone)

<table>
<thead>
<tr>
<th>Description</th>
<th>Date: ___ / ___ / ____ = ____ days since mifepristone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review actual dates medication used:</td>
<td></td>
</tr>
<tr>
<td>Date mifepristone taken:</td>
<td></td>
</tr>
<tr>
<td>Date misoprostol taken:</td>
<td></td>
</tr>
<tr>
<td>Review pre-abortion βhCG on ___ / ___ / ____ result ___ IU</td>
<td></td>
</tr>
<tr>
<td>Post-abortion βhCG on ___ / ___ / ____ result ___ IU</td>
<td></td>
</tr>
<tr>
<td>βhCG &gt; 50% drop from baseline at 3 days post MIFE → successful pregnancy termination</td>
<td></td>
</tr>
<tr>
<td>βhCG &gt; 80% drop from baseline at 7 days post MIFE → successful pregnancy termination</td>
<td></td>
</tr>
<tr>
<td>βhCG &lt; 80% drop from baseline at 7 days post MIFE → order ultrasound</td>
<td></td>
</tr>
<tr>
<td>Ultrasound result on ___ / ___ / ____ (date): ________________  (if done)</td>
<td></td>
</tr>
<tr>
<td>Screen for complications: __________________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Reviewed contraception plan: ___ ____________________________________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

### Follow-up Appointment Signatures

<table>
<thead>
<tr>
<th>Signature of healthcare professional conducting follow-up:</th>
<th>Date:</th>
</tr>
</thead>
</table>

### Notes