

Consent to treatment with MS-2 Step[®] (mifepristone, misoprostol)

Please ensure you have read the accompanying Patient Information Booklet before completing this consent to treatment form. Please note that the risks mentioned in the list below and in the Patient Information Booklet are not exhaustive or inclusive of all possible complications, but are rather the ones generally known or associated with a medical termination of pregnancy.

In addition, please note:

- Possible side effects of this treatment include heavy or prolonged bleeding, severe cramping which may not be relieved by pain medication, nausea, vomiting, diarrhoea, dizziness, headache, fever and chills.
- There is around a 1% (1 in 100) chance that this treatment will fail to end the pregnancy. If this happens, or if the treatment is not completed after it has begun, there is a risk the medications may harm the fetus if the pregnancy continues. Surgical termination or a repeat medical termination is strongly recommended.
- There is up to a 4% (4 in 100) chance of incomplete abortion (retained pregnancy tissue or clot) which may require surgery or more medication.
- There is a 1-2% (1-2 in 100) chance of heavy bleeding (haemorrhage) requiring surgical treatment, and a 0.1-0.2% (1-2 in 1,000) risk of requiring a blood transfusion.
- There is less than 1% (1 in 100) chance of an infection occurring. Although serious infections are very rare in medical termination of pregnancy, they can be potentially life threatening. Symptoms of persistent abdominal pain or feeling unwell or feeling weak with or without a fever following the treatment should be reported to your healthcare practitioner without delay.

Please read carefully before signing:

I, (print name):

of, (print address):

consent to Medical Termination of Pregnancy using mifepristone and misoprostol.

The nature, consequences and risks of this treatment have been explained to me, as well as alternatives, including not proceeding with treatment.

I have been informed of the risks and side effects of this treatment and acknowledge the risks outlined above, including treatment failure which may require a surgical procedure to complete the abortion.

I understand that if I decide not to complete the treatment once it has begun, or if treatment fails to end the pregnancy, there is a risk of harm to the fetus if I continue the pregnancy.

I have discussed and understand how I will access emergency care, if it is needed.

I am aware that I must have follow up 14-21 days after taking MS-2 Step and comply with any other follow up arrangements as advised by my healthcare practitioner.

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I have received written information about the treatment and aftercare which has been discussed and explained to me in a language I understand, and have had the opportunity to ask questions.

I am satisfied that I have been given the opportunity to explore all options regarding my pregnancy and am consenting to termination of this pregnancy of my own freewill.

Patient name:

Signature:

Guardian name
(if required):

Signature:

I confirm that, in my opinion, the patient understands the nature and purpose of the combination of medications used to perform a medical abortion, which has been explained to her in terms suited to her understanding and is able to give informed consent.

Health practitioner name:

Signature:

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