# Consent Form: Embryo(s)/Fetal reduction

I/we _____

Name, Date of Birth

In connection with the high risk of pregnancy loss, associated with my multiple pregnancies, please perform the embryo(s)/fetal reduction.

I explained about embryo/fetal reduction procedures. I informed that the embryo(s)/fetal reduction can lead to the termination of pregnancy.

I declare and confirm that I have received an explanation regarding the intrauterine intervention and the possible side effects:

- bleeding
- septic diseases
- infection
- allergic reaction of local anesthesia.
- thromboembolic complications

Which may require intensive care and/or unplanned surgical intervention (up to the hysterectomy).

I declare that I tell the doctor about all the data known to me about my health, hereditary, STD, mental and other diseases in my family.

I confirm that I have carefully read and understood all the information about the procedure given to me by specialists of the medical organization about the purposes, methods of rendering medical care, the risk associated with them, possible options for medical intervention, its consequences, and also about the expected results. I had an opportunity to discuss with the doctor all questions interesting to me. On all the questions I asked, I was satisfied with the answers. My decision is free and I received a detailed verbal explanation regarding embryo/fetal reduction.

Name of pregnant_____

Signature_____

Date_____

Dr. David Abovyan Ob&Gyn