FORM C

Application for termination of pregnancy/fetal reduction

**I, the undersigned, have been appointed as the legal guardian of:**

|  |  |
| --- | --- |
| Name | Personal reg. no. (CPR) |
| Address | Home/private telephone number |
| Postal code/town | Work telephone number |
| Email address |

**and hereby request a termination of her pregnancy/fetal reduction.**

I declare that I have been instructed by the co-signed physician about the nature and direct consequences of the procedure and the risk that may be assumed to be associated with the procedure. I have also been informed that by contacting the health Region, I will be able to obtain guidance on the available support options should I decide not to terminate the pregnancy and for support after the birth of the child. I have also been advised that abortion applicants, etc. are entitled to support interviews before and after the procedure.

**Signature of legal guardian**

Signature of legal guardian

Date

Location

**I confirm that I have received the above instructions.**

Physician’s signature and stamp

This form must be sent to the hospital together with the admission form. If the referral is made electronically, the signed form must be retained by the referring physician, c.f. the provisions of Chapter 6 of the Danish Authorisations Act (autorisationsloven).

Sekretariatet for Abortankenævnet (Secretariat of the Danish Abortion Appeals Board)
Danish Agency for Patient Complaints

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