FORM B

Application for termination of pregnancy/fetal reduction

**I, the undersigned, have parental custody of:**

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

**You hereby consent to the termination of her pregnancy/fetal reduction.**

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

**Mother’s signature:**

Mother’s signature

Date

Location

**And/or father's signature:**

Father's signature

Date

Location

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

Physician’s signature and stamp

This form must be submitted to the hospital together with form A and 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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