Oregon Health Authority
Center for Health Statistics

PATIENT ID NUMBER: _____	DATE TERMINATION PERFORMED: / /
(*Patient ID/Facility Chart/Case No.*)	(Month/Day/Year)

REPORT OF INDUCED TERMINATION OF PREGNANCY
<u>Facility Worksheet</u>

1. CLINICAL ESTIMATION OF GESTATIONAL AGE

_____ completed weeks

2. NAME OF FACILITY OF TERMINATION: _____

3. LOCATION OF TERMINATION: _____
     (City)   (County)   (State)   (ZIP)

4. Primary procedure that terminated this pregnancy (check only one):

☐ Suction Curettage   ☐ Medical – Mifepristone   ☐ Other medical (Non-surgical); specify medication(s): _____

☐ Dilation and Evacuation (D & E)   ☐ Vaginal Prostaglandin   ☐ Sharp Curettage (D & C)   ☐ Hysterotomy/Hysterectomy

☐ Other (specify): _____

5. Other procedures used for this termination (check all that apply):

☐ Suction Curettage   ☐ Medical – Mifepristone   ☐ Other medical (Non-surgical); specify medication(s): _____

☐ Dilation and Evacuation (D & E)   ☐ Vaginal Prostaglandin   ☐ Sharp Curettage (D & C)   ☐ Hysterotomy/Hysterectomy

☐ Other (specify): _____

6. WAS FOLLOW-UP VISIT RECOMMENDED? ☐ Yes   ☐ No

7. WAS POST-OPERATIVE/AFTER-CARE INFORMATION PROVIDED? ☐ Yes   ☐ No

8. Were there complications at the time of the procedure? ☐ Yes ☐ No

   If yes, specify complications (check all that apply):

☐ Hemorrhage   ☐ Infection   ☐ Uterine perforation   ☐ Cervical laceration
☐ Retained products   ☐ Failure of first method   ☐ Other (specify) _____

9. AT TIME OF COMPLETION OF THIS REPORT, HAD FOLLOW-UP VISIT OCCURRED AT THIS FACILITY?
                                                            ☐ Yes   ☐ No   ☐Unknown

   If **yes**, specify complications (check all that apply)

9a. COMPLICATIONS
☐ None   ☐ Hemorrhage   ☐ Infection   ☐ Uterine perforation   ☐ Cervical laceration
☐ Retained products ☐ Failure of first method   ☐ Other (specify):_____

10. AT TIME OF COMPLETION OF THIS REPORT, HAD FOLLOW-UP VISIT OCCURRED OUTSIDE THIS FACILITY?
                                                            ☐ Yes   ☐ No   ☐Unknown

   If **yes**, specify location of follow-up visit **AND** complications (check all that apply)

10a. TYPE OF LOCATION OF FOLLOW-UP VISIT:
☐ Physician's Office   ☐ Clinic   ☐ Hospital   ☐ Other (specify): _____

10b. COMPLICATIONS:
☐ None   ☐ Hemorrhage   ☐ Infection   ☐ Uterine perforation   ☐ Cervical laceration
☐ Retained products ☐ Failure of first method   ☐ Other (specify): _____

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