

Report Date _____
MM/DD/YYYY

Texas Department of State Health Services Induced Abortion Report Form

Facility Name _____ Facility Code _____

Facility City _____ Facility County _____

TO BE COMPLETED BY PATIENT

- 1) Date of Birth: _____ MM/DD/YYYY
- 2) Married? : Married ☐ Single ☐
- 3) Patient's Race/Ethnicity (Please Choose Only One)
- 1 ☐ Asian
- 2 ☐ Hispanic
- 3 ☐ Caucasian/White
- 4 ☐ African American/Black
- 5 ☐ Native American
- 8 ☐ Other (Specify): _____
- 4) Patient's County of Residence: _____
- 5) Patient's State of Residence: _____

TO BE COMPLETED BY PHYSICIAN

- 6) Abortion Date: _____ MM/DD/YYYY
- 7) Date of Last Menses: _____ MM/DD/YYYY
- 8) Probable Post-Fertilization Age of the Unborn Child: _____
- 9) Number of Previous Live Births: _____
- 10) Number of Previous Induced Abortions: _____
- 11) Patient Viewed Woman's Right to Know Act Material: Yes ☐ No ☐
- 12) Method of Pregnancy Verification (Please Choose Only One)
- 1 ☐ Urine Test
- 2 ☐ Clinical Lab Test
- 3 ☐ Ultrasound
- 4 ☐ Not Tested
- 8 ☐ Other (Specify): _____
- 13) Patient Completed Abortion and Sonogram Election Form: Yes ☐ No ☐
- 14) Was the Patient Under 18 Years of Age? : Yes ☐ No ☐
- 14a) If Under 18, was Consent Addressed? Yes ☐ No ☐
- 15) Type of Termination Procedure (Please Choose Only One)
- 1 ☐ Suction Curettage
- 2 ☐ Medical (Non-Surgical) -- Specify Medication(s): _____
- 3 ☐ Dilation & Evacuation (D&E)
- 4 ☐ Intra-Uterine Instillation (Saline or Prostaglandin)
- 5 ☐ Sharp Curettage (D&C)
- 6 ☐ Hysterotomy/Hysterectomy
- 7 ☐ Other (Specify): _____
- 16) Type of Anesthesia Used:
- 1 ☐ Intravenous Sedation
- 2 ☐ General Anesthesia
- 8 ☐ Other (Specify): _____
- 9 ☐ None
- 17) Complication(s) of Abortion
- 0 ☐ None
- 1 ☐ Shock
- 2 ☐ Uterine Perforation
- 3 ☐ Cervical Laceration
- 4 ☐ Hemorrhage
- 5 ☐ Aspiration/Allergic Response
- 6 ☐ Infection/Sepsis
- 7 ☐ Infant(s) Born Alive
- 8 ☐ Death of Mother
- 9 ☐ Other (Specify): _____
- 18) Method Used to Dispose of Fetal Tissue and Remains: _____
- 19) Did Patient Survive the Induced Abortion? : Yes ☐ No ☐
- 20) Patient's Cause of Death, if Applicable: _____

IF YOUR FACILITY DID NOT PERFORM ABORTIONS, PLEASE CHECK THE BOX BELOW, SIGN, AND RETURN THIS FORM VIA CERTIFIED MAIL TO: DEPT. OF STATE HEALTH SERVICES, VITAL STATISTICS UNIT, DATA MANAGEMENT GROUP, P.O. BOX 4124, AUSTIN, TX 78765-4124.

☐ AUTHORIZED SIGNATURE: _____

12/2013