

REPORT OF

INDUCED TERMINATION OF PREGNANCY

Information is PRIVATE and CONFIDENTIAL

STATE FILE NUMBER

TO BE COMPLETED BY PATIENT

TO BE COMPLETED BY FACILITY

Facility
use only

Facility
use only

1. Patient's ID number:	2. Date termination performed:		3. Patient's age:_____
	/ / (Month/Day/Year)		
4. Patient's residence address:_____			5. Inside city limits? <input type="checkbox"/> Yes <input type="checkbox"/> No
(City) (County) (State) (Zip)			
6. Date last normal menses began:_____	Facility use only	7. Clinical estimation of gestational age:	
(Month/Day/Year)		_____ Completed weeks	
8. Previous live births (enter a number or "none"):		9. Previous terminations (enter a number or "none"):	
a. Live births now living:_____		a. Spontaneous Abortions, Miscarriages, Stillbirths, Fetal Deaths:_____	
b. Live births now dead:_____		b. Induced Abortions (Do NOT include this termination):_____	
10. Marital status: <input type="checkbox"/> Never Married <input type="checkbox"/> Now Married <input type="checkbox"/> Declaration of Oregon Registered Domestic Partnership <input type="checkbox"/> Separated <input type="checkbox"/> Divorced/Dissolution of Domestic Partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown			
11. Education: <input type="checkbox"/> 8th grade or less; none <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Master's degree <input type="checkbox"/> 9th-12th grade; no diploma <input type="checkbox"/> Associate's degree <input type="checkbox"/> Doctorate or professional degree <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Unknown			
12. Is patient of Hispanic origin?		13. Patient's race (select one or more):	
<input type="checkbox"/> No, not Spanish/Hispanic/Latina		<input type="checkbox"/> White <input type="checkbox"/> Black or African American	
<input type="checkbox"/> Yes, Mexican, Mexican-American, Chicano		<input type="checkbox"/> American Indian or Alaska Native	
<input type="checkbox"/> Yes, Puerto Rican		(specify tribe(s)):	
<input type="checkbox"/> Yes, Cuban		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino	
<input type="checkbox"/> Yes, other Hispanic Origin		<input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese	
(specify):		<input type="checkbox"/> Other Asian (specify):	
		<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian or Chamorro	
		<input type="checkbox"/> Other Pacific Islander (specify):	
		<input type="checkbox"/> Other (specify):	
14. Was birth control being used at the time patient became pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, specify method(s) below (check all that apply):			
<input type="checkbox"/> Birth Control Pill <input type="checkbox"/> Hormone Implant <input type="checkbox"/> IUD/IUC <input type="checkbox"/> Patch <input type="checkbox"/> Condoms, Prophylactics <input type="checkbox"/> Rhythm <input type="checkbox"/> NuvaRing			
<input type="checkbox"/> Non-surgical sterilization; e.g., Essure <input type="checkbox"/> Emergency Contraception <input type="checkbox"/> Contraceptive Injection; e.g., Depo-Provera			
<input type="checkbox"/> Other (specify):			
15. Name of facility where termination occurred:_____			
16. Location of termination:_____			
(City) (County) (State) (Zip)			
17. Primary procedure that terminated this pregnancy (check only one):			
<input type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical – Mifepristone <input type="checkbox"/> Other medical (Non-surgical); specify medication(s):			
<input type="checkbox"/> Dilation and Evacuation (D & E) <input type="checkbox"/> Vaginal Prostaglandin <input type="checkbox"/> Sharp Curettage (D & C) <input type="checkbox"/> Hysterotomy/Hysterectomy			
<input type="checkbox"/> Other (specify):			
18. Other procedures used for this termination (check all that apply):			
<input type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical – Mifepristone <input type="checkbox"/> Other medical (Non-surgical); specify medication(s):			
<input type="checkbox"/> Dilation and Evacuation (D & E) <input type="checkbox"/> Vaginal Prostaglandin <input type="checkbox"/> Sharp Curettage (D & C) <input type="checkbox"/> Hysterotomy/Hysterectomy			
<input type="checkbox"/> None <input type="checkbox"/> Other (specify):			
19. Was follow-up visit recommended? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. Was post-operative/after-care information provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Were there complications at the time of the procedure ? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, specify complications (check all that apply):			
<input type="checkbox"/> Hemorrhage <input type="checkbox"/> Infection <input type="checkbox"/> Uterine perforation <input type="checkbox"/> Cervical laceration			
<input type="checkbox"/> Retained products <input type="checkbox"/> Failure of first method <input type="checkbox"/> Other (specify):			
22. At time of completion of this report, had follow-up visit occurred at this facility ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, specify complications (check all that apply):			
22a. Complications:			
<input type="checkbox"/> None <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Infection <input type="checkbox"/> Uterine perforation <input type="checkbox"/> Cervical laceration			
<input type="checkbox"/> Retained products <input type="checkbox"/> Failure of first method <input type="checkbox"/> Other (specify):			
23. At time of completion of this report, had follow-up visit occurred outside this facility ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, specify location of follow-up visit AND specify complications (check all that apply):			
23a. Type of location of follow-up visit:			
<input type="checkbox"/> Physician's Office <input type="checkbox"/> Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify):			
23b. Complications:			
<input type="checkbox"/> None <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Infection <input type="checkbox"/> Uterine perforation <input type="checkbox"/> Cervical laceration			
<input type="checkbox"/> Retained products <input type="checkbox"/> Failure of first method <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify):			

WHEN COMPLETING THIS FORM,
DO NOT WRITE OR STAMP ANY INFORMATION IN THE TOP RIGHT CORNER.
This space is required for recording the state file number.

DO NOT PUNCH HOLES IN THE TOP OF THIS FORM.
This prevents us from using our numbering machine for assigning state file numbers.
You may punch holes in the bottom or sides.

**SEND COMPLETED FORMS TO: CENTER FOR HEALTH STATISTICS
P.O. BOX 14050
Portland, OR 97293-0050**

“Induced Termination of Pregnancy” is defined as “the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and that does not result in a live birth.” This definition excludes management of prolonged retention of products of conception following fetal death.

In accordance with ORS 435.496, each induced termination of pregnancy which occurs in the State of Oregon, regardless of the length of gestation, shall be reported to the Center for Health Statistics within 30 days by the person in charge of the institution in which the induced termination was performed or, if not in an institution, by the attending physician.

This report is designed to collect information for statistical and research purposes only and is not maintained as a permanent file at the Center for Health Statistics. The data gathered from this report are presented in aggregate statistics only. By law, no identifying information is collected about the abortion patient and all provider information is kept strictly confidential.

It is the responsibility of each abortion provider to obtain an answer for each of the questions asked on this form. For information about completing the data items on this form, you can contact 971-673-1160 or you can refer to the “Instructions for Completing The Report of Induced Termination of Pregnancy.”

The instructions are available online at:
<http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/ITOPInstruct.aspx>

Additional copies of this form can also be downloaded at the above listed web address.

Additional forms may also be ordered and mailed to you by completing a Request for Vital Records Forms and Tags, Form 45-43.

The request form is available by calling 971-673-1180, or online at:
<http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Documents/45-43.pdf>.

This report may also be filed electronically through the Oregon Vital Events Registration System (OVERS). Please contact the OVERS team at 971-673-0279 if you are interested in learning more about using OVERS to submit reports electronically.