Texas Department of State Health Services
Induced Abortion Report Form
For Abortions Occurring on or After January 1, 2016

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**

A) Was Proof of the Patient’s Identity Obtained? Yes ☐ No ☐
B) Was Proof of the Patient’s Age Obtained? Yes ☐ No ☐
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 ☐ Dilatation & 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. Publication Number: 35-11254
☐ AUTHORIZED SIGNATURE: __________________________
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