# 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**: _________________________________

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### TO BE COMPLETED BY PATIENT

1. **Date of Birth**: ____________________
2. **Married?**: Married [ ] Single [ ]
3. **Patient’s Race/Ethnicity (Please Choose Only One)**
   - [ ] Asian
   - [ ] Hispanic
   - [ ] Caucasian/White
   - [ ] African American/Black
   - [ ] Native American
   - [ ] Other (Specify): ____________________________
4. **Patient’s County of Residence**: ______________________________
5. **Patient’s State of Residence**: __________________________________
   - [ ] Native American
   - [ ] Other (Specify): ___________

### TO BE COMPLETED BY PHYSICIAN

6. **Abortion Date**: _______________
7. **Date of Last Menses**: _______________
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)**
    - [ ] Urine Test
    - [ ] Clinical Lab Test
    - [ ] Ultrasound
    - [ ] Not Tested
    - [ ] 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)**
    - [ ] Suction Curettage
    - [ ] Medical (Non-Surgical) – Specify Medication(s): ____________________________
    - [ ] Dilatation & Evacuation (D&E)
    - [ ] Intra-Uterine Instillation (Saline or Prostaglandin)
    - [ ] Sharp Curettage (D&C)
    - [ ] Hysterotomy/Hysterectomy
    - [ ] Other (Specify): _______________________________________________________________________
16. **Type of Anesthesia Used**:
    - [ ] Intravenous Sedation
    - [ ] General Anesthesia
    - [ ] Other (Specify): ____________________________
    - [ ] None
17. **Complication(s) of Abortion**:
    - [ ] None
    - [ ] Shock
    - [ ] Uterine Perforation
    - [ ] Cervical Laceration
    - [ ] Hemorrhage
    - [ ] Aspiration/Allergic Response
    - [ ] Infection/Sepsis
    - [ ] Infant(s) Born Alive
    - [ ] Death of Mother
    - [ ] 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**: _______________________________________________________________________

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**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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