

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
- 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) Weeks of Gestation: _____
- 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
 - 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: _____