Save Print Reset

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

ABORTION REPORT

STATE FILE NUMBER

TYPE/PRINT IN PERMANENT BLACK INK.

1a. FACILITY - NAME (If not Hospital or Clinic, Give Address)

1b. CITY, TOWN, OR LOCATION OF ABORTION

1c. COUNTY OF ABORTION

2a. PATIENT NUMBER

2b. AGE OF PATIENT LAST BIRTHDAY

2c. MARITAL STATUS *(Specify)*

☐ 0 Never Married ☐ 2 Widowed ☐ 4 Separated

☐ 1 Married ☐ 3 Divorced ☐ 5 Unmarried, Unspecified

3. DATE OF ABORTION *(Month, Day, Year)*

4a. RESIDENCE - CITY, TOWN, OR LOCATION

4b. INSIDE CITY LIMITS *(Check)* ☐ 1 Yes ☐ 2 No

4c. STATE

4d. ZIP CODE

4e. COUNTY

5. RACE *(Check)*

1 ☐ White
2 ☐ Black
3 ☐ American Indian
4 ☐ Other *(specify)* _____

6. OF HISPANIC ORIGIN? *(specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)*

☐ 0 No
☐ 1 Yes
Specify _____

7. EDUCATION *(Specify only highest grade completed)*

ELEMENTARY OR SECONDARY (0-12)	COLLEGE (1-4 OR 5+)

8. PREVIOUS PREGNANCIES (Complete Each Section)

LIVE BIRTHS

8a. NOW LIVING	8b. NOW DEAD
Number _____	Number _____
None ☐	None ☐

OTHER TERMINATIONS

8c. SPONTANEOUS	8d. INDUCED *(Do not include this abortion.)*
Number _____	Number _____
None ☐	None ☐

9. PROCEDURE USED TO COMPLETE ABORTION - TYPE OF TERMINATION PROCEDURE *(CHECK ONLY ONE)*

1 ☐ Suction Curettage
2 ☐ Sharp Curettage (D & C)
3 ☐ Intra-Uterine Instillation (saline or prostaglandin)
4 ☐ Hysterotomy/Hysterectomy
5 ☐ Medical (non-surgical)
Specify _____
8 ☐ Laminaria (D & E)
9 ☐ Other *(specify)* _____

10. CERTIFICATIONS OF PHYSICIAN WHO PERFORMED OR INDUCED THE ABORTION:

a. Physician certifies they have no knowledge that the woman sought the abortion solely because of a prenatal diagnosis, test, or screening indicating Down Syndrome or of the potential of Down Syndrome in the unborn child. ☐ Yes ☐ No

b. Physician certifies they have no knowledge that the woman sought the abortion solely because of the sex or race of the unborn child. ☐ Yes ☐ No

c. Physician certifies the abortion was due to a "medical emergency", a condition which, based on reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the pregnant woman or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman. ☐ Yes ☐ No

11. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

12a. CLINICAL ESTIMATION OF GESTATION

_____ weeks

12b. METHOD OF ESTIMATING GESTATION:

1 ☐ Ultrasound
2 ☐ Fundal height
8 ☐ Other (specify) _____

13. BIPARIETAL DIAMETER MEASUREMENT

_____ mm

If gestational age ≥ 18 weeks by LNM or clinical estimate

14. FETUS VIABLE?

1 ☐ Yes 2 ☐ No

1. Has the patient ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? ☐ Yes ☐ No

2. If answering question (1) in the affirmative, would the patient like to receive information and assistance regarding the Department of Health and Senior Service's veteran services? ☐ Yes ☐ No

15a. NAME OF PHYSICIAN WHO PERFORMED OR INDUCED THE ABORTION (Type or print)

15b. SIGNATURE NAME OF PHYSICIAN WHO PERFORMED OR INDUCED THE ABORTION

15c. MISSOURI PHYSICIAN LICENSE NUMBER

Within 45 days from the date of abortion, submit this form to:

Department of Health and Senior Services
Attention: Bureau of Vital Records
P.O. Box 570
Jefferson City, MO 65012

Name of Person Completing Report (Type or Print)