

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMPLICATION REPORT FOR POST-ABORTION CARE

PATIENT	Patient Number 1a.	Date of Birth (Mo., Day, Yr.) 1b.	Residence-State 1c.	County 1d.	City, Town or Location 1e.	Date of Abortion (Mo., Day, Yr.) 2.
FACILITY WHERE ABORTION WAS PERFORMED	Facility Name 3a.		Street Address 3b.		City, Town or Location 3c.	State 3d.
FACILITY REPORTING COMPLICATION	Facility Name 4a.		Street Address 4b.		City, Town or Location 4c.	State 4d.
	Was Patient Previously Seen at Another Facility for Post-Abortion Care? 5a. Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Name of Facility 5b.		Street Address 5c.	City, Town or Location 5d.	State 5e.
COMPLICATIONS: Incomplete Abortion..... <input type="checkbox"/> Excessive Bleeding After Discharge..... <input type="checkbox"/> Endometritis..... <input type="checkbox"/> Parametritis..... <input type="checkbox"/> Pyrexia..... <input type="checkbox"/> Abscess, Pelvic..... <input type="checkbox"/> Uterine Perforation..... <input type="checkbox"/> Failed Abortion, Pregnancy Undisturbed..... <input type="checkbox"/> Cramps..... <input type="checkbox"/> Skin Reaction..... <input type="checkbox"/> Psychiatric..... <input type="checkbox"/> 6. Other (Describe)..... <input type="checkbox"/>					PLEASE CHECK ONE OR MORE: Hysterectomy <input type="checkbox"/> Death of Woman <input type="checkbox"/> Transfusion <input type="checkbox"/> Other (Describe) <input type="checkbox"/> 7. _____ Was Patient Hospitalized Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Name of Hospital _____ ----- Hospital – Street Address _____ ----- Hospital – City, Town, Location _____ 8. _____	
PHYSICIAN PROVIDING CARE	Name of Attending Physician (Type or Print) 9a.			Signature of Attending Physician 9b.		Date of This Post-Abortion Care (Mo., Day, Yr.) 10.