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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

REPORT OF INDUCED TERMINATION OF PREGNANCY

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 PREGNANCY TERMINATION

1c. COUNTY OF PREGNANCY TERMINATION

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 PREGNANCY TERMINATION *(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

Number _____

None ☐

8b. NOW DEAD

Number _____

None ☐

OTHER TERMINATIONS

8c. SPONTANEOUS

Number _____

None ☐

8d. INDUCED *(Do not include this termination.)*

Number _____

None ☐

9. PROCEDURE THAT TERMINATED PREGNANCY

TYPE OF TERMINATION PROCEDURES

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

11a. CLINICAL ESTIMATION OF GESTATION

_____ weeks

11b. METHOD OF ESTIMATING GESTATION:

1 ☐ Ultrasound

2 ☐ Fundal height

8 ☐ Other (specify) _____

12. BIPARIETAL DIAMETER MEASUREMENT

_____ mm

If gestational age ≥ 18 weeks by LNM or clinical estimate

13. FETUS VIABLE?

1 ☐ Yes 2 ☐ No

If yes, submit physician's signed statements certifying "the medical threat posed to the life of the pregnant woman, or the medical reasons that continuation of the pregnancy would cause a serious risk of substantial and irreversible physical impairment of a major bodily function".

14a. NAME OF ATTENDING PHYSICIAN (Type or print)

14b. SIGNATURE OF ATTENDING PHYSICIAN

14c. MISSOURI PHYSICIAN LICENSE NUMBER

15. NAME OF PERSON COMPLETING REPORT (If other than Attending Physician)

16a. NAME OF CONCURRING PHYSICIAN, IF FETUS VIABLE (Type or Print)

16b. SIGNATURE OF CONCURRING PHYSICIAN, IF FETUS VIABLE

16c. CONCURRING PHYSICIAN LICENSE NUMBER