STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

COMPLICATION REPORT FOR POST-ABORTION CARE

PATIENT	1A. PATIENT NUMBER	1B. DATE OF BIRTH (MO/DAY/YR)	1C. RESIDENCE-STATE	1D. COUNTY	1E. CITY, TOWN OR LOCATION	2. DATE OF ABORTION (MO/DAY/YR)

FACILITY WHERE ABORTION WAS PERFORMED	3A. FACILITY NAME	3B. STREET ADDRESS	3C. CITY, TOWN OR LOCATION	3D. STATE	3E. TYPE OF ABORTION PERFORMED ☐ Surgical ☐ Medical (Non-surgical)

FACILITY REPORTING COMPLICATION	4A. FACILITY NAME	4B. STREET ADDRESS	4C. CITY, TOWN OR LOCATION		4D. STATE
	5A. WAS PATIENT PREVIOUSLY SEEN AT ANOTHER FACILITY FOR POST-ABORTION CARE? ☐ YES ☐ NO	5B. IF YES, NAME OF FACILITY	5C. STREET ADDRESS	5D. CITY, TOWN OR LOCATION	5E. STATE

6. COMPLICATIONS (PLEASE CHECK ALL THAT APPLY)

- ☐ Incomplete Abortion
- ☐ Hemorrhage
- ☐ Endometritis
- ☐ Parametritis
- ☐ Pyrexia
- ☐ Abscess, Pelvic
- ☐ Uterine Perforation
- ☐ Failed Medical Abortion
- ☐ Failed Surgical Abortion, Immediately recognized
- ☐ Failed Surgical Abortion, with delayed recognition
- ☐ Retained Products
- ☐ Cervical Lacerations
- ☐ Diagnosable Psychiatric Condition
- ☐ Other (Describe): _____

7. RESULT OF COMPLICATION (PLEASE CHECK ALL THAT APPLY)

- ☐ Hysterectomy
- ☐ Death of Woman
- ☐ Transfusion
- ☐ Other (Describe): _____

8. WAS PATIENT HOSPITALIZED?
☐ YES ☐ NO

IF YES, NAME OF HOSPITAL

HOSPITAL - STREET ADDRESS

HOSPITAL - CITY, TOWN, LOCATION

PHYSICIAN PROVIDING CARE

9A. NAME OF PHYSICIAN (TYPE OR PRINT)	9B. SIGNATURE OF PHYSICIAN	10. DATE OF THIS POST-ABORTION CARE (MO/DAY/YR)

Within 45 days from the date of post-abortion care for complication, submit this form to:

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