



REPORT OF INDUCED TERMINATION OF PREGNANCY

STATE FILE NUMBER

1. Patient's ID Number (Do Not Enter Patient's Name)	2. Age (Last Birthday)	3. Date of Pregnancy Termination (Month, Day, Year)
4. Facility Name	5. City/Town or Location of Pregnancy Termination	6. County of Pregnancy Termination

7. Residence - State or Foreign Country	8. Residence - County
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9. Of Hispanic Origin? <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican/Mexican American/Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina Specify _____	10. Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____	11. Education (Specify the highest degree or level completed) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th -12th grade no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate or professional degree (e.g., PhD, MD)
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12. Patient Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Date Last Normal Menses Began (Month, Day, Year)
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14. Previous Pregnancies	
LIVE BIRTHS	OTHER TERMINATIONS
14a. Now Living NUMBER _____ <input type="checkbox"/> NONE	14b. Now Dead NUMBER _____ <input type="checkbox"/> NONE
14c. Spontaneous NUMBER _____ <input type="checkbox"/> NONE	14d. Induced (DO NOT INCLUDE THIS TERMINATION) NUMBER _____ <input type="checkbox"/> NONE

(Pursuant to Chapter 41, Title 44, of the Code of Laws of South Carolina, 1976, as amended)

15. Was a Determination of Probable Postfertilization Age Made? <input type="checkbox"/> YES - Go to question 17 <input type="checkbox"/> NO - Go to question 16	18. If Probable Postfertilization Age is 20 or more weeks: a. Was the reason for the abortion? <input type="checkbox"/> Medical Emergency, go to Question 18b. <input type="checkbox"/> Fetal Anomaly, go to Question 18c. b. If Medical Emergency, provide the basis of the determination that the pregnant woman had a condition which so complicated her medical condition as to necessitate the abortion of her pregnancy to avert her death or to avert the serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions: Specify: _____ Go to Question 18c. c. Was the method of abortion used one that, in reasonable medical judgment, provided the best opportunity for the unborn child to survive? <input type="checkbox"/> Yes. Go to question 20 <input type="checkbox"/> No. Go to question 19
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16. Enter the basis of the determination that a medical emergency existed: Specify: _____ Go to question 20

17. Probable Postfertilization Age 17a. Enter weeks of Probable Postfertilization Age: _____ 17b. Was Ultrasound used to determine Probable Postfertilization Age? <input type="checkbox"/> YES <input type="checkbox"/> NO If less than 20 weeks Probable Postfertilization Age, go to question 20 If 20 weeks or MORE Probable Postfertilization Age, go to question 18	19. Provide the basis of the determination that termination of the pregnancy in that manner (best opportunity) would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions, of the woman than would other available methods: Specify: _____
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20. TERMINATION PROCEDURES

20a. PRIMARY PROCEDURE USED TO TERMINATE THE PREGNANCY (CHECK ONLY ONE)	20b. ADDITIONAL PROCEDURES USED IF ANY (CHECK ALL THAT APPLY)
Check Only One Primary Procedure	Check all Additional Procedures Used
<input type="checkbox"/> Dilation and Curettage (D&C)	<input type="checkbox"/>
<input type="checkbox"/> Manual Vacuum Aspiration	<input type="checkbox"/>
<input type="checkbox"/> Electrical Vacuum Aspiration.....	<input type="checkbox"/>
<input type="checkbox"/> Dilation and Evacuation (D&E)	<input type="checkbox"/>
<input type="checkbox"/> Combined Induction Abortion and Dilatation and Evacuation.....	<input type="checkbox"/>
<input type="checkbox"/> Medication Abortion (such as, but not limited to, mifepristone/misoprostol or methotrexate/misoprostol)	<input type="checkbox"/>
<input type="checkbox"/> Induction Abortion with Prostaglandins	<input type="checkbox"/>
<input type="checkbox"/> Induction Abortion with Intra-Amniotic Instillation (such as, but not limited to, saline or urea)	<input type="checkbox"/>
<input type="checkbox"/> Induction Abortion - Other	<input type="checkbox"/>
<input type="checkbox"/> Hysterotomy/Hysterectomy	<input type="checkbox"/>
<input type="checkbox"/> Intact Dilatation and Extraction (partial birth)	<input type="checkbox"/>
<input type="checkbox"/> Other - Specify	<input type="checkbox"/>

21. Was an intra-fetal injection used in an attempt to induce fetal demise (such as, but not limited to, intra-fetal potassium chloride or digoxin)? <input type="checkbox"/> YES <input type="checkbox"/> NO

ITEM 22 MUST BE COMPLETED FOR EACH PATIENT, REGARDLESS OF AGE.	22a. WAS INFORMED WRITTEN CONSENT OBTAINED FROM THE PATIENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	22c. IF PATIENT HAS BEEN COURT ADJUDGED MENTALLY INCOMPETENT, INFORMED WRITTEN CONSENT OBTAINED FROM: (check one) 1 <input type="checkbox"/> Spouse 2 <input type="checkbox"/> Parent 3 <input type="checkbox"/> Legal Guardian 4 <input type="checkbox"/> None of the above
	22b. IF NO, INFORMED WRITTEN CONSENT WAS NOT OBTAINED DUE TO: (check one) 1 <input type="checkbox"/> Medical Emergency 2 <input type="checkbox"/> Incest 3 <input type="checkbox"/> Not Capable/Mentally Incompetent 4 <input type="checkbox"/> None of the above	

ITEM 23 MUST BE COMPLETED FOR EACH PATIENT, UNDER 17 YEARS OF AGE.	23a. IF PATIENT IS UNDER 17 YEARS OF AGE, ADDITIONAL INFORMED WRITTEN CONSENT OBTAINED FROM:(check one) 1 <input type="checkbox"/> Parent 2 <input type="checkbox"/> Legal Guardian 3 <input type="checkbox"/> Grandparent 4 <input type="checkbox"/> Person in Loco Parentis 5 <input type="checkbox"/> None of the above	23b. IF PATIENT IS UNDER 17 YEARS OF AGE AND ADDITIONAL INFORMED WRITTEN CONSENT WAS NOT OBTAINED, CHECK REASON BELOW: (check one) 1 <input type="checkbox"/> Emancipated Minor 2 <input type="checkbox"/> Court Order 3 <input type="checkbox"/> Medical Emergency 4 <input type="checkbox"/> Incest 5 <input type="checkbox"/> None of the above
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24. Date Report Completed
