

Siselle

SFN:003073

TERMINATED PREGNANCY REPORT
INDIANA STATE DEPARTMENT OF HEALTH - VITAL RECORDS
Per IC 16-34-2

** If the patient is less than sixteen (16) years of age the physician performing the termination shall transmit this report to the Department of Child Services within three (3) days after the termination is performed via email at dcs Hollinereports@dcs.in.gov. Further, this report shall also be submitted to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana State Department of Health no later than 30 days after each termination is performed. Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address WHOLE WOMAN'S HEALTH OF SOUTH BEND - 3511 LINCOLN WAY W., SOUTH BEND, IN, 46828		City or town, of pregnancy termination SOUTH BEND	County of pregnancy termination ST. JOSEPH
Patient's age** 18	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination 05/16/2020	Education 8th Grade or Less
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input checked="" type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Live Births:	Number now living 0	Number now deceased 0	
Other Terminations:	Number of spontaneous terminations 0	Number of induced terminations 0	
Dates of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	List any preexisting medical conditions of the patient that may complicate the abortion Complication(s) of Pregnancy Termination <input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration <input type="checkbox"/> Infection <input type="checkbox"/> Retained Products <input type="checkbox"/> Other (Specify) Did this termination of pregnancy result in a maternal death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		

Type of Termination Procedures	
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> Medical (Nonsurgical) Mifepristone <input checked="" type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)	Additional Procedure that Terminated Pregnancy <input type="checkbox"/> Medical (Nonsurgical) Mifepristone <input type="checkbox"/> Medical (Nonsurgical) Misoprostol <input type="checkbox"/> Medical (Nonsurgical) Other (Specify) For Medical (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Medical (Surgical) Suction Curettage <input type="checkbox"/> Medical (Surgical) Menstrual Aspiration <input type="checkbox"/> Medical (Surgical) Other (Specify)
For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)	For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)

Date last normal menses began 03/26/2020	Physician estimate of gestation (in weeks) 6	Post fertilization age of the fetus (in weeks) 4
How were the gestational age and post fertilization age determined? BASED ON SELF REPORTED LMP AND ULTRASOUND CONFIRMED GESTATIONAL AGE		
Was a waiver of consent obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Was a waiver of notification obtained? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Is the patient seeking an abortion as a result of being any of the following? <input type="checkbox"/> Abused <input type="checkbox"/> Coerced <input type="checkbox"/> Harassed <input type="checkbox"/> Trafficked		
Full name of physician performing termination DR. BARBARA L. WILLIAMS		
Address of physician performing termination (number and street, city, state, and zip code) 3511 LINCOLN WAY WEST, SOUTH BEND, IN 46828		



**Date Reported to DCS, if Patient under 16 (month, day, year): _____
DATE RECEIVED BY ISDH (month, day, year): 05/16/2020