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 dcshotlinereports@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	City or town, of pregnancy termination	County of pregnancy termination
WHOLE WOMAN'S HEALTH OF SOUTH BEND - 3511 LINCOLN WAY W., SOUTH BEND, IN, 46628	SOUTH BEND	ST. JOSEPH

Patient's age**	Married	Date of pregnancy termination	Education
19	[ ] Yes [x] No	11/02/2019	Unknown

Race: [ ] American Indian or Alaska Native [ ] Asian [x] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] White [ ] Other [ ] Unknown

Ethnicity: [ ] Hispanic or Latino [x] Not Hispanic or Latino [ ] 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? [ ] Yes [x] No
If yes, length of time fetus survived:

Fetus viable? [ ] Yes [x] No
If viable, medical reason for termination:

Pathological examination performed? [ ] Yes [x] No
If yes, results:

List any preexisting medical conditions of the patient that may complicate the abortion

Complication(s) of Pregnancy Termination
[ ] None [ ] Uterine Perforation
[ ] Hemorrhage [ ] Cervical Laceration
[ ] Infection [x] Retained Products
[ ] Other *(Specify)*

Did this termination of pregnancy result in a maternal death? [ ] Yes [x] No

Type of Termination Procedures

Procedure that Terminated Pregnancy

[x] Medical (Nonsurgical) Mifepristone
[x] Medical (Nonsurgical) Misoprostol
[ ] Medical (Nonsurgical) Other *(Specify)*

For Medical (Nonsurgical) procedures, answer the following question
Check the box indicating the following items were completed
[x] The manufacturer's instructions provided to the patient
[x] The patient signed the patient agreement

[ ] Medical (Surgical) Suction Curettage
[ ] Medical (Surgical) Menstrual Aspiration
[ ] 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? [ ] Yes [ ] No
If the previous question was answered yes, complete the following questions.
Was the fetus given the best opportunity to survive? [ ] Yes [ ] 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)

Additional Procedure that Terminated Pregnancy

[ ] Medical (Nonsurgical) Mifepristone
[ ] Medical (Nonsurgical) Misoprostol
[ ] Medical (Nonsurgical) Other *(Specify)*

For Medical (Nonsurgical) procedures, answer the following question
Check the box indicating the following items were completed
[ ] The manufacturer's instructions provided to the patient
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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	Physician estimate of gestation *(in weeks)*	Post fertilization age of the fetus *(in weeks)*
09/07/2019	8	7

How were the gestational age and post fertilization age determined?
BASED ON SELF REPORTED LMP AND ULTRASOUND GESTATIONAL AGE

Was a waiver of consent obtained? [ ] Yes [x] No
Was a waiver of notification obtained? [ ] Yes [x] No

Is the patient seeking an abortion as a result of being any of the following? [ ] Abused [ ] Coerced [ ] Harassed [ ] Trafficked

Full name of physician performing termination
DR. MEERA JUGALKISHOR SHAH

Address of physician performing termination *(number and street, city, state, and zip code)*
3511 LINCOLN WAY WEST, SOUTH BEND, IN 46624

**Date Reported to DCS, if Patient under 16 *(month, day, year)*: ______

DATE RECEIVED BY ISDH *(month, day, year)*: 12/16/2019

SFN:007441

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WHOLE WOMAN'S HEALTH OF SOUTH BEND - 3511 LINCOLN WAY W., SOUTH BEND, IN, 46628	SOUTH BEND	ST. JOSEPH

Patient's age**	Married	Date of pregnancy termination	Education
38	[ ] Yes [X] No	12/07/2019	High School Diploma or GED

Race: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [X] White [ ] Other [ ] Unknown

Ethnicity: [ ] Hispanic or Latino [X] Not Hispanic or Latino [ ] Unknown

Live Births:	Number now living: 1	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. ______

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If yes, length of time fetus survived:

Fetus viable? [ ] Yes [X] No
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List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)

Date last normal menses began	Physician estimate of gestation *(in weeks)*	Post fertilization age of the fetus *(in weeks)*
11/06/2019	4	6

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? [ ] Yes [X] No
Was a waiver of notification obtained? [ ] Yes [X] No

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3511 LINCOLN WAY WEST, SOUTH BEND, IN 46624

**Date Reported to DCS, if Patient under 16 *(month, day, year)*: ______

DATE RECEIVED BY ISDH *(month, day, year)*: 01/03/2020