REPORT OF COMPLICATION(S) RESULTING FROM INDUCED TERMINATION OF PREGNANCY
Confidential record for medical and health use
(SEE BACK OF FORM FOR DEFINITION AND REPORTING INSTRUCTIONS)

PLEASE TYPE OR PRINT IN BLACK INK

DATE(S) OF SERVICE

Month Day Year — Month Day Year
1. Date Service Began: — 2. Date Service Ended:

ENTITY PROVIDING TREATMENT

3. Name: (If not hospital or clinic, give address or other identification)

PATIENT INFORMATION

4. County:

5. City or Town: — Inside City Limits? ☐ Yes ☐ No

6. Race (Check only one box) ☐ 1 White ☐ 2 Black ☐ 3 American Indian ☐ 4 Other (Specify)_____

7. Age:

8. Married? ☐ Yes ☐ No

9. Education (Specify only HIGHEST grade COMPLETED)
Elementary OR Secondary (0-12) — College (1 - 4, 5+)

10. Previous Pregnancies (Complete all four sections; enter number or check None)

Live Births		Other Terminations	
a. Now Living	b. Now Dead	c. Spontaneous Abortions, Miscarriages, Stillbirths and Fetal Deaths	d. Induced Abortions
Number _____ None 00 ☐	Number _____ None 00 ☐	Number _____ None 00 ☐	Number _____ None 00 ☐

COMPLICATION(S) REQUIRING TREATMENT

11. Patient Condition(s) Requiring Treatment: (Check all that apply)

☐ 1 Pelvic Infection
☐ 2 Hemorrhage
☐ 3 Damage to Pelvic Organs
☐ 4 Renal Failure
☐ 5 Metabolic disorder
☐ 6 Shock
☐ 7 Embolism
☐ 8 Coma
☐ 9 Death
☐ 10 Other, Specify_____

AMOUNT BILLED FOR SERVICES RENDERED AND ENTITY BILLED
(CODES MUST DISTINGUISH TREATMENT FOLLOWING INDUCED ABORTIONS FROM TREATMENTS FOLLOWING ECTOPIC OR MOLAR PREGNANCIES)

ATTACH ADDITIONAL SHEETS AS NEEDED

12. ICD-9 Code:	13. Amount Billed:	14. Entity Billed: (Medicaid, Insurance, Private Pay, Other)

MEDICAL INFORMATION FOR TERMINATION RESULTING IN REPORTABLE COMPLICATIONS

Month Day Year
15. Date Termination Performed:

16. Facility Where Induced Termination was Performed: (Name and Address)

17. Type of Termination Procedure:
☐ 1. Suction Curettage
☐ 2. Hysterotomy/Hysterectomy
☐ 3. Dilation and Evacuation (D&E)
☐ 4. Intra-Uterine Instillation (Saline or Prostaglandin)
☐ 5. Sharp Curettage (D&C)
☐ 6. Medical (Nonsurgical), Specify Medication(s)_____
☐ 7. Other, Specify_____
☐ 8. Unknown

PERSON COMPLETING REPORT

18. Name and Title: (Type or Print)

19. Telephone Number:

INSTRUCTIONS FOR REPORTING COMPLICATION(S) RESULTING FROM INDUCED TERMINATION OF PREGNANCY

DEFINITION: Abortion - the intentional termination of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus. Medical treatment means but is not limited to hospitalization, laboratory tests, surgery, or prescription of drugs.

REPOR TING REQUIREMENTS OF MISSISSIPPI STATE DEPARTMENT OF HEALTH:

Coverage	A physician shall file a written report with the State Department of Health regarding each patient who comes under the physician's professional care and requires medical treatment or suffers death that the attending physician has a reasonable basis to believe is a primary, secondary, or tertiary result of an induced abortion.
Time Allowed	Submit each report within thirty (30) days of the discharge or death of the patient treated for the complication.
Responsibility for Reporting	The attending physician is responsible for reporting.
Reporting Address	Send completed reports to: Mississippi State Department of Health Vital Records P. O. Box 1700 Jackson, Mississippi 39215-1700

For additional forms or further information, write to Vital Records, visit www.msdh.state.ms.us or call 576-7960.

CONFIDENTIALITY :

Although the State Department of Health requires all complication(s) resulting from induced terminations of pregnancy be reported, it does not require the patient be identified by name, address, social security number or motor vehicle operator's license number or other information or identifiers making it possible to identify an individual who has obtained an abortion. The Department shall summarize aggregate data from the reports for purposes of inclusion into the annual Vital Statistics Report.

SPECIFIC INSTRUCTIONS:

Item 3.	If the patient was seen in a physician's office which does not have a clinic name, use the name of the physician, for example, "Dr. Smith's office."
Item 5.	The state and county shown should be the actual location of the patient's home regardless of the mailing address. For example, if a patient lives in Rankin County and her mailing address is a rural route out of Jackson, the county listed should be Rankin even though the city of Jackson is in Hinds County. The same rule applies if an out-of-state address is involved. For example, if a patient whose home is in Marshall County, Mississippi has a Collierville, Tennessee mailing address, Mississippi and Marshall County should be listed as state and county of residence, but the city can be listed as Collierville, Tennessee, outside.
Item 6.	If Other is checked, enter specific race (or races, if of mixed racial background).
Item 8.	If patient is separated from her husband but not divorced, check Yes.
Item 9.	Enter the **highest** grade or college year **completed** in "regular" schooling. Do not enter any levels below the highest one completed.
Item 10.	All four sections must be completed either by entering a number or by checking None. Do not use dashes or other symbols which have no specific meaning.
Item 13.	This should include charges for physician, hospital, emergency room, prescription or other drugs, laboratory tests and any other costs for the treatment rendered.
Item 16.	If the procedure was performed in a physician's office which does not have a clinic name, use the name of the physician, for example, "Dr. Smith's office."
Item 17.	Check only one procedure. If more than one procedure was used, check the one which, in the attending physician's judgement, is the primary one that actually terminated the pregnancy.
Item 18.	No signature is required. Enter name for reference in case record is incomplete or requires clarification.