# REPORT OF INDUCED TERMINATION OF PREGNANCY PERFORMED IN MISSISSIPPI

Confidential Record of Medical and Health Use

(SEE BACK OF FORM FOR DEFINITION AND REPORTING INSTRUCTIONS)

**PLEASE TYPE OR PRINT IN BLACK INK**

FILING DATE

STATE FILE NUMBER **123-**

**DATE OF PREGNANCY TERMINATION**

1. Month Day Year

**PLACE OF TERMINATION**

2. Facility Name (If not a hospital or clinic, give address or other identification)

3. County

4. City or Town

**PATIENT INFORMATION**

5. Residence (Enter actual location rather than mailing address)

a. State | b. County | c. City or Town | d. Inside City Limits? ☐ Yes ☐ No

6. Patient's Identification Number Assigned By Facility

7. Age

8. Married? ☐ Yes ☐ No

9. Race (Check one or more races to indicate what the patient considers herself to be)

☐ White ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Samoan

☐ Asian Indian ☐ Guamanian or Chamorro ☐ Other Asian (Specify)_____ ☐ Other Pacific Islander (Specify _____

☐ American Indian or Alaska Native (Name of the enrolled tribe or principle tribe) _____ ☐ Other (Specify) _____

10. Patient of Hispanic Origin? Check the box that best describes whether the patient of Spanish/Hispanic/Latino.

☐ No, Not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican

☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (Specify) _____ ☐ Unknown

11. Patient's Education – Check the box that best describes the highest degree or level of school completed.

☐ 8th grade or less ☐ 9th – 12th grade, no diploma ☐ High school graduate or GED completed ☐ Some college, no degree

☐ Associate degree (e.g., AA, AS) ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)

☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown

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

| Live Births | | Other Pregnancy Outcomes | |
|---|---|---|---|
| a. Now Living<br>Number _____<br>None 00 ☐ | b. Now Dead<br>Number _____<br>None 00 ☐ | c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths<br>Number _____<br>None 00 ☐ | d. Induced Abortions<br>(Do NOT include this termination)<br>Number _____<br>None 00 ☐ |

**MEDICAL INFORAMTION FOR THIS TERMINATION**

13. Clinical Estimate Weeks of Gestation
Completed Weeks _____

14. Date Last menses Began (Month, Day, Year)

15. Type of Termination Procedure (Check **only** one)

☐ 1 Suction curettage

☐ 2 Medical/Non-surgical – Mifepristone (RU486, Mifeprex)

☐ Other Medical Nonsurgical (Specify) _____

☐ 3 Dilation and Evacuation (D&E)

☐ 4 Intrauterine instillation (Saline, Prostaglandin)

☐ 5 Sharp Curettage (D&C)

☐ 6 Hysterotomy/Hysterectomy

☐ 7 Other (Specify) _____

☐ 9 Unknown

15a. Additional procedures used (Check all that apply)

☐ 0 No Additional procedures used

☐ 1 Suction curettage

☐ 2 Medical/Non-surgical Mifepristone (RU486, Mifeprex)

☐ Other Medical Nonsurgical (Specify)_____

☐ 3 Dilation and Evacuation (D&E)

☐ 4 Intrauterine instillation (Saline, Prostaglandin)

☐ 5 Sharp Curettage (D&C)

☐ 6 Hysterotomy/Hysterectomy

☐ 7 Other (Specify) _____

☐ 9 Unknown

**ATTENDING PHYSICIAN**

16. Name (Type or print)

**PERSON COMPLETING REPORT**

17. Name (Type or print)

18. Title

# INSTRUCTIONS FOR REPORTING INDUCED TERMINATION OF PREGNANCY

## DEFINITION:

The intentional termination of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus.

## REPORTING REQUIREMENTS OF MISSISSIPPI STATE DEPARTMENT OF HEALTH:

| | |
|---|---|
| Coverage | Report each induced termination of pregnancy performed in Mississippi. |
| Time Allowed | Submit each report within 5 days after the event. |
| Responsibility for Reporting | A. If the termination was performed in an institution, the person in charge of the institution is responsible for reporting.<br>B. If the termination was not performed in an institution, the attending physician is responsible for reporting. |
| Reporting Address | Send completed reports to:<br>Vital Records<br>P. O. Box 1700<br>Jackson, Mississippi 39215-1700<br><br>For additional forms or further information, write to Vital Records or call 601-206-8200. |

## CONFIDENTIALITY:

Although the State Department of Health requires that all induced terminations of pregnancy be reported, it does not require that the patient be identified by name or address. The reports will be used for medical and health purposes and will not be incorporated into the permanent official records of the vital statistics registration system.

## SPECIFIC INSTRUCTIONS:

| | |
|---|---|
| Item 4. | 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 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, along with the Mississippi city of their residence |
| Item 6. | The identification number can be the patient number assigned by the facility in its usual record keeping procedures or can be a special number assigned for this report. In any event, the number should enable the facility staff to access the record again should it be necessary for Vital Records to send a query because an item was overlooked, not clear, etc. |
| Item 8. | If the patient is separated from her husband but not divorced, check Yes. |
| Item 9. | Check as many of the races that the patient considers herself to be. If the race is not listed, check "Other" and specify the race. |
| Item 10. | Check the specific origin if listed. If the patient is not of Spanish/Hispanic/Latino origin, check "No, not Spanish/Hispanic/Latino". |
| Item 11. | Check the box that describes the HIGHEST level of education completed. |
| Item 12. | All four sections must be completed either by entering the number or by checking None. Do not use dashes or other symbols which have no specific meaning. |
| Item 13. | Provide the estimate in completed weeks. |
| Item 14. | Enter the complete date if known. If any part of the date is unknown, enter 99 for that part. |
| Item 15. | 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 induced termination. |
| Item 15a. | Check any additional (if any) procedures used. If no additional procedure was used, check None. |
| Item 16. | No signature required. Enter name for reference in case the record is incomplete or requires clarification. |
| Item 17. | No signature required. Enter name for reference in case the record is incomplete or requires clarification. |