LOUISIANA DEPARTMENT OF HEALTH
Public Health

For Vital Records Use Only

Date Received: _____/_____/_____

ITOP SFN: _____

Individual Complication Report for Post-Abortion Care
For Healthcare Facilities

Date of Termination: _____ Patient Identification Number (if known): _____

Facility where Abortion Occurred

Facility _____

Address _____

City _____ State _____ Zip Code _____

Nature of Abortion Complication Diagnosed or Treated

Facility where Post-Abortion Care Occurred

Facility _____

Address _____

City _____ State _____ Zip Code _____

Signature: _____ Date: _____

After completing, print and mail to:
Vital Records Registry
PO Box 60630
New Orleans, LA 70160

Rev 8/2021