

REPORT OF INDUCED TERMINATION OF PREGNANCY PERFORMED IN LOUISIANA

IMPORTANT:
Type or print in
permanent black ink.

**NOTE: Failure to complete and file this form is a crime (see LSA-R.S. 40:66
and 40:1299.35.10) and is punishable by fine and/or imprisonment.**

Certificate No. _____

FACILITY	1a. FACILITY NAME (If not hospital or clinic, give address)		1b. CITY, TOWN OR LOCATION OF PREGNANCY TERMINATION		1c. DATE OF PREGNANCY TERMINATION	
PATIENT INFORMATION	2a. PATIENT IDENTIFICATION NUMBER		2b. AGE OF PATIENT	2c. MARRIED? (Check) Yes No Unk. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		3. PARISH AND STATE OF RESIDENCE
	4a. MEDICAL CONDITION AT TIME OF ABORTION		4b. Rh TYPE	4c. TYPE OF CONTRACEPTIVE AT TIME OF PREGNANCY	4d. DATE OF LAST LIVE BIRTH (Month, Day, Year)	
	4e. DATE OF LAST PREVIOUS TERMINATION (Month, Day, Year)		6. EDUCATION (Specify only highest grade completed)			
	5. RACE (Check) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Other (Specify) _____		Elementary or Secondary (0-12)		College (12-16 or 17+)	
INFORMATION ON FATHER (of Fetus)	8a. FATHER'S AGE		8b. RESIDENCE - STATE		8c. PARISH OF RESIDENCE	
	8d. FATHER MARRIED? Yes No Unk. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		PREVIOUS PREGNANCIES (Complete each section)			
	7a. Now Living Number _____ None <input type="checkbox"/>		7b. Now Dead Number _____ None <input type="checkbox"/>		7c. Spontaneous Number _____ None <input type="checkbox"/>	
	7d. Induced Number _____ None <input type="checkbox"/>		OTHER TERMINATIONS			
TERMINATION PROCEDURE, COMPLICATIONS, REASON FOR TERMINATION, POST ABORTION PROCEDURE	9a. PROCEDURE THAT TERMINATED PREGNANCY (Check only one) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/>		TYPE OF TERMINATION PROCEDURE Suction Curettage Sharp Curettage Intra-Uterine Saline Instillation Intra-Uterine Prostaglandin Instillation Hysterotomy Hysterectomy Dilation and Evacuation Other (Specify) _____		9b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY (Check all that apply) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8	
	9c. COMPLICATION OF PREGNANCY TERMINATION (Check all that apply) 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Hemorrhage 3 <input type="checkbox"/> Infection 4 <input type="checkbox"/> Uterine Perforation 5 <input type="checkbox"/> Cervical Laceration 6 <input type="checkbox"/> Retained Products 7 <input type="checkbox"/> Other (Specify) _____		9d. REASON FOR PREGNANCY TERMINATION (Check only one) 1 <input type="checkbox"/> Mental Health of Mother 2 <input type="checkbox"/> Physical Health of Mother 3 <input type="checkbox"/> Risk of Fetal Deformity 4 <input type="checkbox"/> Rape or Incest 5 <input type="checkbox"/> Other (Specify) _____ 9 <input type="checkbox"/> Unknown		9e. TYPE OF PROCEDURE DONE AFTER ABORTION (Check only one) 1 <input type="checkbox"/> Tubal Ligation 2 <input type="checkbox"/> Hysterectomy 3 <input type="checkbox"/> Other (Specify) _____ 4 <input type="checkbox"/> None	
FETAL INFORMATION	10a. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)		10b. PHYSICIAN'S ESTIMATE OF GESTATION Weeks		10c. FETAL LENGTH CM	
	10d. FETAL WEIGHT Grams		10e. OTHER SIGNIFICANT CONDITIONS OF FETUS		10f. TYPE OF POST ABORTION PROCEDURE	
PHYSICIAN	10g. RESULT OF PATHOLOGICAL EXAMINATION		11a. TYPE OF FAMILY PLANNING RECOMMENDED TO PATIENT		11b. TYPE OF ADDITIONAL COUNSELING GIVEN TO PATIENT	
	11c. SIGNATURE/ADDRESS OF PHYSICIAN		11d. PHYSICIAN'S LICENSE NO.			

IMPORTANT: This report and accompanying certificates and consent forms required by LSA-R.S. 40:1299.35.10(25) must be submitted to the Vital Records Registry within 15 days of the abortion. Please staple/attach documents to the back of this form.