All fields are required for statistical purposes. Do not leave fields blank; either select “unknown” or “other” and write “unknown” if field is not known.

Oregon Health Authority
Center for Health Statistics

REPORT OF INDUCED TERMINATION OF PREGNANCY

Information is PRIVATE and CONFIDENTIAL

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STATE FILE NUMBER

TO BE COMPLETED BY PATIENT

Facility use only

1. Patient's ID number: (Patient ID/Facility Chart/Case No.)
2. Date termination performed: / / (Month/Day/Year)
3. Patient's age:
4. Patient's residence address: (City) (County) (State) (Zip)
5. Inside city limits? ☐ Yes ☐ No
6. Date last normal menses began: / / (Month/Day/Year)

Facility use only

7. Clinical estimation of gestational age: Completed weeks
8. Previous live births (enter a number or "none"):
   a. Live births now living:
   b. Live births now dead:
9. Previous terminations (enter a number or "none"):
   a. Spontaneous Abortions, Miscarriages, Stillbirths, Fetal Deaths:
   b. Induced Abortions (Do NOT include this termination):
10. Marital status: ☐ Never Married ☐ Now Married ☐ Declaration of Oregon Registered Domestic Partnership ☐ Separated ☐ Divorced/Dissolution of Domestic Partnership ☐ Widowed ☐ Unknown
11. Education: ☐ 8th grade or less; none ☐ 9th-12th grade; no diploma ☐ High school graduate or GED ☐ Some college credit, but no degree ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate or professional degree ☐ Unknown
12. Is patient of Hispanic origin?
    ☐ No, not Spanish/Hispanic/Latina
    ☐ Yes, Mexican, Mexican-American, Chicano
    ☐ Yes, Puerto Rican
    ☐ Yes, Cuban
    ☐ Yes, other Hispanic Origin
13. Patient's race (select one or more):
    ☐ White ☐ Black or African American
    ☐ American Indian or Alaska Native (specify tribe(s)):
    ☐ Asian Indian ☐ Chinese ☐ Filipino
    ☐ Japanese ☐ Korean ☐ Vietnamese
    ☐ Other Asian (specify):
    ☐ Native Hawaiian ☐ Samoan ☐ Guamanian or Chamorro
    ☐ Other Pacific Islander (specify):
    ☐ Other (specify):

If not known, check ‘Other’ box and type “unknown”

14. Was birth control being used at the time patient became pregnant? ☐ Yes ☐ No ☐ Unknown
    If yes, specify method(s) below (check all that apply):
    ☐ Birth Control Pill ☐ Hormone Implant ☐ IUD/IUC ☐ Patch ☐ Condoms, Prophylactics ☐ Rhythm ☐ NuvaRing
    ☐ Non-surgical sterilization; e.g., Essure ☐ Emergency Contraception ☐ Contraceptive Injection; e.g., Depo-Provera
    ☒ Other (specify): Unknown

TO BE COMPLETED BY FACILITY

15. Name of facility where termination occurred:
16. Location of termination: (City) (County) (State) (Zip)
17. Primary procedure that terminated this pregnancy (check only one):
    ☐ Suction Curettage ☐ Medical – Mifepristone ☐ Other medical (Non-surgical); specify medication(s):
    ☐ Dilation and Evacuation (D & E) ☐ Vaginal Prostaglandin ☐ Sharp Curettage (D & C) ☐ Hysterotomy/Hysterectomy
    ☐ Other (specify):
18. Other procedures used for this termination (check all that apply):
    ☐ Suction Curettage ☐ Medical – Mifepristone ☐ Other medical (Non-surgical); specify medication(s):
    ☐ Dilation and Evacuation (D & E) ☐ Vaginal Prostaglandin ☐ Sharp Curettage (D & C) ☐ Hysterotomy/Hysterectomy
    ☐ None ☐ Other (specify):
19. Was follow-up visit recommended? ☐ Yes ☐ No
20. Was post-operative/after-care information provided? ☐ Yes ☐ No
21. Were there complications at the **time of the procedure?** ☐ Yes ☐ No
    If yes, specify complications (check all that apply):
    ☐ Hemorrhage ☐ Infection ☐ Uterine perforation ☐ Cervical laceration
    ☐ Retained products ☐ Failure of first method ☒ Other (specify): Unknown

If not known, check ‘Other’ box and type “unknown”

22. At time of completion of this report, had follow-up visit occurred **at this facility?** ☐ Yes ☐ No ☐ Unknown
    If yes, specify complications (check all that apply):
    22a. Complications:
    ☐ None ☐ Hemorrhage ☐ Infection ☐ Uterine perforation ☐ Cervical laceration
    ☐ Retained products ☐ Failure of first method ☒ Other (specify): Unknown
23. At time of completion of this report, had follow-up visit occurred **outside this facility?** ☐ Yes ☐ No ☐ Unknown
    If yes, specify location of follow-up visit AND specify complications (check all that apply):
    23a. Type of location of follow-up visit:
    ☐ Physician's Office ☐ Clinic ☐ Hospital ☐ Unknown ☒ Other (specify): Unknown
    23b. Complications:
    ☐ None ☐ Hemorrhage ☐ Infection ☐ Uterine perforation ☐ Cervical laceration
    ☐ Retained products ☐ Failure of first method ☐ Unknown ☒ Other (specify): Unknown

If “yes”, must specify. If not known, check ‘Other’ box and type “unknown”

PLEASE COMPLETE THIS FORM NO SOONER THAN 2 WEEKS FOLLOWING THE DATE OF TERMINATION.
FORM MUST BE SUBMITTED NO LATER THAN 30 DAYS FOLLOWING THE DATE OF TERMINATION OF PREGNANCY.

(See information on the back side of this form.) 45-113 (01/15)