

OREGON DEPARTMENT OF HUMAN SERVICES
Center for Health Statistics
REPORT OF INDUCED TERMINATION OF PREGNANCY

136- _____ State File Number

1. NAME OF FACILITY _____		FACILITY CHART OR CASE NO. _____	
2. FACILITY ADDRESS _____ (CITY OR TOWN) (COUNTY)		3. DATE TERMINATION PERFORMED: _____ (MONTH) (DAY) (YEAR)	
4. PATIENT'S USUAL RESIDENCE _____ (STATE) (COUNTY) (CITY OR TOWN) (ZIP CODE) (INSIDE CITY LIMITS - YES, NO)			
5. AGE LAST BIRTHDAY _____	6. MARITAL STATUS: 1 <input type="checkbox"/> Never Married 3 <input type="checkbox"/> Widowed 5 <input type="checkbox"/> Separated 2 <input type="checkbox"/> Now Married 4 <input type="checkbox"/> Divorced 6 <input type="checkbox"/> Unknown		
7. IS PATIENT OF HISPANIC ORIGIN? 0 <input type="checkbox"/> NO <input type="checkbox"/> YES, specify Cuban, Mexican, Puerto Rican, etc. _____		8. RACE (select one or more): 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> American Indian 4 <input type="checkbox"/> Chinese 5 <input type="checkbox"/> Japanese 6 <input type="checkbox"/> Hawaiian 8 <input type="checkbox"/> Filipino 0 <input type="checkbox"/> Other Asian <input type="checkbox"/> Other (specify) _____	
9. EDUCATION _____ (Indicate a NUMBER for the HIGHEST grade COMPLETED): →		None (0)	Elementary/Secondary (1-12)
			College (1-4, 5+)
10. PREVIOUS PREGNANCIES (Complete all four sections; enter number or check None)			
Live Births		Other Terminations	
a. Now Living Number _____ None 00 <input type="checkbox"/>	b. Now Dead Number _____ None 00 <input type="checkbox"/>	c. Spontaneous Abortions, Miscarriages, Stillbirths, and Fetal Deaths Number _____ None 00 <input type="checkbox"/>	d. Induced Abortions (Do not include this termination) Number _____ None 00 <input type="checkbox"/>
11. DATE LAST NORMAL MENSES BEGAN _____ Month Day Year		12. CLINICAL ESTIMATE OF GESTATION _____ Completed weeks	
13. WAS PREGNANCY THE RESULT OF A CONTRACEPTIVE FAILURE? 1 <input type="checkbox"/> NO 2 <input type="checkbox"/> YES If Yes, specify method below. 1 <input type="checkbox"/> Birth Control Pill 2 <input type="checkbox"/> Foam 3 <input type="checkbox"/> Hormone Implant e.g. Norplant 4 <input type="checkbox"/> Diaphragm 5 <input type="checkbox"/> IUD 6 <input type="checkbox"/> Condoms, Prophylactics 7 <input type="checkbox"/> Rhythm 8 <input type="checkbox"/> Other, specify _____ 9 <input type="checkbox"/> Contraceptive Injection e.g. Depo Provera			
14. PROCEDURE THAT TERMINATED THIS PREGNANCY (Check only one) 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical) specify medication(s) _____ 3 <input type="checkbox"/> Dilation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (saline/prostaglandin) 5 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 7 <input type="checkbox"/> Hysterotomy/Hysterectomy 8 <input type="checkbox"/> Other (specify) _____			
15. OTHER PROCEDURES USED FOR THIS TERMINATION (Check all that apply) 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Suction Curettage 2 <input type="checkbox"/> Medical (nonsurgical) specify medication(s) _____ 3 <input type="checkbox"/> Dilation and Evacuation (D & E) 4 <input type="checkbox"/> Intra-Uterine Instillation (saline or prostaglandin) 5 <input type="checkbox"/> Vaginal Prostaglandin 6 <input type="checkbox"/> Sharp Curettage (D & C) 8 <input type="checkbox"/> Other (specify) _____			
16. WAS WRITTEN POST-OPERATIVE/AFTER-CARE INFORMATION GIVEN TO PATIENT? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
17. WAS FOLLOW-UP VISIT RECOMMENDED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
18. COMPLICATIONS AT TIME OF PROCEDURE (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
19. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED AT THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES, If yes, specify complications (check all that apply): 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____			
20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED OUTSIDE THIS FACILITY? 2 <input type="checkbox"/> NO 1 <input type="checkbox"/> YES 3 <input type="checkbox"/> UNKNOWN If yes, specify complications (check all that apply) & complete item 20a below: 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Hemorrhage 2 <input type="checkbox"/> Infection 3 <input type="checkbox"/> Uterine perforation 4 <input type="checkbox"/> Cervical laceration 5 <input type="checkbox"/> Retained products 6 <input type="checkbox"/> Failure of first method 7 <input type="checkbox"/> Other (specify) _____ 9 <input type="checkbox"/> Unknown 20A. If yes, specify location of follow up visit: 1 <input type="checkbox"/> Physicians Office 2 <input type="checkbox"/> Clinic 3 <input type="checkbox"/> Hospital 4 <input type="checkbox"/> OTHER, SPECIFY _____			

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

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