DEPARTMENT OF STATE HEALTH SERVICES
INDUCED ABORTION REPORT FORM

I. FACILITY NAME _____ FACILITY CODE _____

CITY _____ COUNTY _____

II. REPORTING PERIOD _____ DATE FORM COMPLETED _____

(MM/DD/YYYY – MM/DD/YYYY) (MM/DD/YYYY)

IV. ABORTION INFORMATION – DO NOT IDENTIFY BY ANY MEANS THE PATIENT OR THE PHYSICIAN WHO PERFORMED THE ABORTION.

PATIENT NUMBER 1	ABORTION DATE (MM/DD/YYYY)	TYPE OF TERMINATION (Check only one. Check the box that describes the procedure that actually terminated this pregnancy.) 1 ☐ Suction Curettage 2 ☐ Medical (Non-surgical) – Specify Medication(s):_____ 3 ☐ Dilation and Evacuation (D&E) 4 ☐ Intra-Uterine Instillation (Saline or Prostaglandin) 5 ☐ Sharp Curettage (D&C) 6 ☐ Hysterotomy/Hysterectomy 7 ☐ Other – Specify: _____				DATE LAST NORMAL MENSES BEGAN (MM/DD/YYYY)	WEEKS OF GESTATION (2-digit WHOLE number)
	RESIDENCE (State and County)	DATE OF BIRTH (MM/DD/YYYY)	RACE	MARRIED? ☐ YES ☐ NO	# OF PREVIOUS LIVE BIRTHS	# OF PREV. INDUCED ABORTIONS	PATIENT SURVIVED? ☐ YES ☐ NO	

PRINT CLEARLY OR TYPE.

PATIENT NUMBER 2	ABORTION DATE (MM/DD/YYYY)	TYPE OF TERMINATION (Check only one. Check the box that describes the procedure that actually terminated this pregnancy.) 1 ☐ Suction Curettage 2 ☐ Medical (Non-surgical) – Specify Medication(s):_____ 3 ☐ Dilation and Evacuation (D&E) 4 ☐ Intra-Uterine Instillation (Saline or Prostaglandin) 5 ☐ Sharp Curettage (D&C) 6 ☐ Hysterotomy/Hysterectomy 7 ☐ Other – Specify: _____				DATE LAST NORMAL MENSES BEGAN (MM/DD/YYYY)	WEEKS OF GESTATION (2-digit WHOLE number)
	RESIDENCE (State and County)	DATE OF BIRTH (MM/DD/YYYY)	RACE	MARRIED? ☐ YES ☐ NO	# OF PREVIOUS LIVE BIRTHS	# OF PREV. INDUCED ABORTIONS	PATIENT SURVIVED? ☐ YES ☐ NO	

FOLLOW ATTACHED INSTRUCTIONS CAREFULLY.

PATIENT NUMBER 3	ABORTION DATE (MM/DD/YYYY)	TYPE OF TERMINATION (Check only one. Check the box that describes the procedure that actually terminated this pregnancy.) 1 ☐ Suction Curettage 2 ☐ Medical (Non-surgical) – Specify Medication(s):_____ 3 ☐ Dilation and Evacuation (D&E) 4 ☐ Intra-Uterine Instillation (Saline or Prostaglandin) 5 ☐ Sharp Curettage (D&C) 6 ☐ Hysterotomy/Hysterectomy 7 ☐ Other – Specify: _____				DATE LAST NORMAL MENSES BEGAN (MM/DD/YYYY)	WEEKS OF GESTATION (2-digit WHOLE number)
	RESIDENCE (State and County)	DATE OF BIRTH (MM/DD/YYYY)	RACE	MARRIED? ☐ YES ☐ NO	# OF PREVIOUS LIVE BIRTHS	# OF PREV. INDUCED ABORTIONS	PATIENT SURVIVED? ☐ YES ☐ NO	

DO NO LEAVE ANY BLANKS!

PATIENT NUMBER 4	ABORTION DATE (MM/DD/YYYY)	TYPE OF TERMINATION (Check only one. Check the box that describes the procedure that actually terminated this pregnancy.) 1 ☐ Suction Curettage 2 ☐ Medical (Non-surgical) – Specify Medication(s):_____ 3 ☐ Dilation and Evacuation (D&E) 4 ☐ Intra-Uterine Instillation (Saline or Prostaglandin) 5 ☐ Sharp Curettage (D&C) 6 ☐ Hysterotomy/Hysterectomy 7 ☐ Other – Specify: _____				DATE LAST NORMAL MENSES BEGAN (MM/DD/YYYY)	WEEKS OF GESTATION (2-digit WHOLE number)
	RESIDENCE (State and County)	DATE OF BIRTH (MM/DD/YYYY)	RACE	MARRIED? ☐ YES ☐ NO	# OF PREVIOUS LIVE BIRTHS	# OF PREV. INDUCED ABORTIONS	PATIENT SURVIVED? ☐ YES ☐ NO	

QUESTIONS? CALL DATA MANAGEMENT: 1-888-963-7111 ext. 2585

PATIENT NUMBER 5	ABORTION DATE (MM/DD/YYYY)	TYPE OF TERMINATION (Check only one. Check the box that describes the procedure that actually terminated this pregnancy.) 1 ☐ Suction Curettage 2 ☐ Medical (Non-surgical) – Specify Medication(s):_____ 3 ☐ Dilation and Evacuation (D&E) 4 ☐ Intra-Uterine Instillation (Saline or Prostaglandin) 5 ☐ Sharp Curettage (D&C) 6 ☐ Hysterotomy/Hysterectomy 7 ☐ Other – Specify: _____				DATE LAST NORMAL MENSES BEGAN (MM/DD/YYYY)	WEEKS OF GESTATION (2-digit WHOLE number)
	RESIDENCE (State and County)	DATE OF BIRTH (MM/DD/YYYY)	RACE	MARRIED? ☐ YES ☐ NO	# OF PREVIOUS LIVE BIRTHS	# OF PREV. INDUCED ABORTIONS	PATIENT SURVIVED? ☐ YES ☐ NO	

IF YOUR FACILITY DID NOT PERFORM ABORTIONS AS DEFINED IN THE HEALTH AND SAFETY CODE, CHAPTER 245, ABORTION FACILITIES, PLEASE CHECK THE BOX BELOW, SIGN YOUR NAME AND RETURN THIS FORM IN AN ENVELOPE MARKED "CONFIDENTIAL" BY CERTIFIED MAIL TO: TEXAS VITAL STATISTICS, DATA MANAGEMENT GROUP, P. O. BOX 4124, AUSTIN, TX 78765-4124.

☐ AUTHORIZED SIGNATURE: _____