

INSTRUCTIONS FOR COMPLETING THE REPORT OF INDUCED TERMINATION OF PREGNANCY

ITEM 1. NAME OF FACILITY (If not clinic or hospital, give address) -

Enter the full name of the hospital or clinic where the induced termination of pregnancy occurred.

If the induced termination of pregnancy occurred in a hospital or a clinic that is physically situated within a hospital or is administratively a part of a hospital, enter the full name of the hospital.

If the induced termination of pregnancy occurred in a freestanding clinic, a clinic that is physically and administratively separate from a hospital, enter the full name of the clinic.

If the induced termination of pregnancy occurred in a physician's office or some other place, enter the name of the physician.

Item 1 provides information about the types of facilities where induced terminations are performed.

FACILITY CHART OR CASE NUMBER -

Enter the hospital, clinic, or other patient identification number. This number must be one that would enable the facility or physician to access the medical file of this patient.

We can't suggest strongly enough that you indicate some type of chart or case number that will enable **you** to identify a patient when follow up is required.

This information is used with Items 1 and 2 for querying of missing information without identifying the patient. We would strongly suggest that each facility/physician indicate this information for their ease in identifying the correct chart when clarification of information is requested by the Center for Health Statistics.

ITEM 2. FACILITY ADDRESS - (City or Town and County)

Enter the name of the city, town or location where the pregnancy termination occurred.

Enter the name of the county where the pregnancy termination occurred.

ITEM 3. DATE TERMINATION PERFORMED - (Month, Day, Year)

Enter the exact month, day, and year of the pregnancy termination.

The date the pregnancy was actually terminated should be entered. This may not necessarily be the date the procedure was begun.

EXCEPTION: For termination procedures performed by medical (nonsurgical) methods, the date of the termination should be recorded as the actual date the initial dosage of medication(s) was (were) given-not the actual date of expulsion of pregnancy.

This information is used to determine when the pregnancy termination occurred and to determine the length of gestation. Length of gestation is an essential element in the study of risks associated with induced termination.

ITEM 4. PATIENT'S USUAL RESIDENCE - (State, County, City or Town, Zip Code, Inside City Limits)

The patient's residence is the place where her household is located. This is not necessarily the same as her "home State," "voting residence," "mailing address," or "legal residence." The state, county, and city should be that of the place where the patient actually lives. Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Residence for a short time at the home of a relative or friend is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is NOT considered temporary and should be entered as the place of residence of the patient on the report

If the patient has been living in a facility where an individual usually resides

for a long period of time, such as a group home, mental institution, nursing home, penitentiary or hospital for the chronically ill, this facility should be entered as the place of residence.

RESIDENCE - STATE

Enter the name of the state where the patient lives. This may differ from the state in her mailing address. If the patient is not a resident of the United States, enter the name of the country and the name of the unit of government that is the nearest equivalent of a state. An appendix has been included, showing the correction abbreviation for each state.

RESIDENCE - COUNTY

Enter the name of the county where the patient lives. An appendix has been included that will assist in the correct selection of the county for a specified city/town.

RESIDENCE - CITY, TOWN, OR LOCATION

Enter the name of the city, town, or location where the patient lives. This may differ from the city, town, or location in her mailing address.

RESIDENCE ZIP CODE

Enter the Zip Code of the place where the patient lives.

RESIDENCE - INSIDE CITY LIMITS - (Yes or No)

Enter "Yes" if the city or town entered is incorporated and the patient's residence is inside its boundaries. Otherwise, enter "No".

You should be asking the patient this question and recording her response. Do not leave this item blank. This office is required to code selected cities determined by the population of that city/town based on the latest population census figures. If the city/town reported requires one of these mandatory codes and the city limits questions is left blank, those reports will be returned to you for completion of this item.

These items provide data for the analysis of induced termination by residence of

the patient. This information is used with the city and county of termination to provide information on the amount of movement occurring within a State or between States to obtain an induced termination of pregnancy.

ITEM 5. AGE LAST BIRTHDAY -

Enter the age of the patient in years at her last birthday. Some facilities obtain the patient's date of birth rather than age. An appendix has been included that will assist you in the conversion of the patient's date of birth to her correct age.

This information permits analysis of health risks related to length of pregnancy and type of procedure among different age groups. It is also used to study the impact of induced terminations on the fertility rates of different age groups.

ITEM 6. MARITAL STATUS -

Specify never married, now married, widowed, divorced, separated, or unknown. **DO NOT USE "SINGLE"**.

This information is used to study the health risks of induced terminations by marital status. It also helps determine the impact of induced terminations on the fertility rates of married and unmarried women and aids in planning for and evaluating the effectiveness of family planning programs.

ITEM 7. IS PATIENT OF HISPANIC ORIGIN? (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)

Check "No" or "Yes". If "Yes" is checked, enter the specific Hispanic group or country of origin as obtained from the patient. Do not leave this item blank. The entry in this item should reflect the response of the patient.

For the purposes of this item, "Hispanic" refers to people whose origins are from Spain, Mexico, Puerto Rico, Cuba, or the Spanish-speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality, lineage, or country in which the patient or her ancestors were

born before their arrival in the United States.

There is no set rule as to how many generations are to be taken into account in determining Hispanic origin. A patient may report Hispanic origin based on the country of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the patient considers herself to be and is not based on percentages of ancestry. Although the prompts include the major Hispanic groups of Cuban, Mexican, and Puerto Rican, other Hispanic groups can also be identified in the space provided.

If a patient indicates that she is of multiple Hispanic origin, enter the origins as reported (for example, Mexican-Puerto Rican).

If a patient indicates that she is Mexican-American or Cuban-American, enter the Hispanic origin as stated.

This item is not a part of the Race item. A person of Hispanic origin may be of any race. "Race" and "Hispanic origin" should be asked independently.

Hispanics comprise the second largest minority in this country. This item provides data to measure differences in pregnancy outcome and variations in health care for people of Hispanic and non-Hispanic origin. Without collection of data on persons of Hispanic origin, it is impossible to obtain valid demographic and health information on Hispanic Americans.

ITEM 8. RACE

Select - - White, Black, American Indian, Chinese, Japanese, Hawaiian, Filipino, Other Asian, or Other (specify)_____.

Check the box that describes the race of the patient. The entry in this item should reflect the response of the patient.

We have expanded the check box categories, so there will be less use of the "other" specify category. We have included an appendix that will assist in the selection of a race category based on the information provided by the patient.

If the patient is not one of the races specified, use "Other" and specify the race on the line provided.

If race is indicated as Asian or Pacific Islander, enter the national origin of the patient, such as Chinese, Japanese, Hawaiian, Filipino, Other Asian (check boxes). Do not use Asian, Oriental, Yellow or Mongolian as race.

If the patient is of mixed race, check all that apply.

Information on race is needed to study the impact of induced terminations on the birth, fertility, and out-of-wedlock rates of different racial groups.

ITEM 9. EDUCATION - (Specify only highest grade completed)

None (0)

Elementary/Secondary (1-12)

College (1-4, 5+)

Enter the highest number of years of regular schooling completed by the patient in either the space for elementary/secondary school or the space for college. An entry should be made in only one of the spaces. The other spaces should be left blank.

We have included an appendix that will assist in the correct selection of education based on the information provided by the patient. We are asking that you report only the highest grade completed. For example if the patient says she is a Senior in college, you would report her education level as "3" in the college field, likewise if the patient says she was a Junior in high school, her education would be reported as "10" in the elementary/secondary field. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

Count formal schooling including community college and universities. Do not include beauty, barber, trade, business, technical, or other special schools when determining the highest grade completed.

There may be a misunderstanding of the education item for some patients educated in foreign countries. Some people use the term "college" to

indicate what we would specify as "high school" in this country. Some use the word "university" to indicate higher education. If you have a patient that received their education in a foreign country, try to determine if they are using the term "college" to refer to high school or university education.

This item is an important indicator of socioeconomic status of the patient. This information is used for studying the effect of induced terminations on the health and fertility of various educational and socioeconomic groups. This information is also useful in planning educational programs that address family planning.

ITEM 10. PREVIOUS PREGNANCIES (Complete all four sections, enter number or check "None")

a. NOW LIVING -

Number _____ None

Enter the number of children born alive to this patient who are still living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are dead.

b. NOW DEAD -

Number _____ None

Enter the number of children born alive to this patient who are no longer living at the time of this termination. Do not include children by adoption. Check "None" if all previous children are still living.

c. SPONTANEOUS ABORTIONS, MISCARRIAGES, STILLBIRTHS, AND FETAL DEATHS

Number _____ None

Enter the number of previous pregnancies that ended spontaneously and did not result in a live born infant. This should not include induced terminations. Check "None" if the patient has had no previous pregnancies or if all previous pregnancies ended in live born infants.

d. INDUCED ABORTIONS (Do not include this termination)

Number _____ None

Enter the number of previous induced terminations (induced abortions) that this patient has had. Do not include this termination. Check "none" if the patient has had no previous induced terminations.

This information provides a pregnancy history and allows for insight into the use of induced terminations to limit family size. Because this item also collects information on the number of previous induced terminations, it provides some data on characteristics of women who may need alternative methods of family planning.

ITEM 11. DATE LAST NORMAL MENSES BEGAN - (Month, Day, Year)

Enter the exact date (month, day, and year) of the first day of the patient's last normal menstrual period, as obtained from the hospital or clinic record or the patient herself.

If the exact day is unknown but the month and year are known, obtain an estimate of the day from the patient, her physician, or the medical record. If an estimate of the date cannot be obtained, enter the month and year only. Enter "Unknown" if the date cannot be determined. Do not leave this item blank.

This item is used in conjunction with the date of termination to determine the length of gestation. Gestational age is important in evaluating the effectiveness and safety of the various termination procedures.

ITEM 12. CLINICAL ESTIMATE OF GESTATION - (Completed Weeks)

Enter the length of gestation as estimated by the attending physician in completed menstrual weeks. Do not compute this information from the date last normal menses began and date of termination. If the attendant has not done a clinical estimate of gestation, enter "None." Do not leave this item blank.

For termination procedures performed by medical (nonsurgical) methods,

gestational age should be recorded as the gestational age of the pregnancy as of the day the **initial** dosage of medication(s) was (were) given.

This item provides a check on the length of gestation as calculated from date of last normal menses. It permits the physician to report an estimate when there is doubt as to the accuracy of the length of gestation or when date of last normal menses is unavailable or misleading.

ITEM 13. WAS PREGNANCY THE RESULT OF A CONTRACEPTIVE FAILURE?

No Yes If yes, specify contraceptive method

Birth Control Pill, Foam, Hormone Implant (e.g. Norplant), Diaphragm, IUD, Condoms-Prophylactics, Rhythm, Contraceptive Injection (e.g. Depo Provera), Other (specify) _____

Hormone Implant/(e.g. Norplant): This category might include other brand name drugs that are Levonorgestrel. Space restrictions do not allow us to list all possible brand names, so we have chosen the most commonly recognized name.

Contraceptive Injection/(e.g. Depo Provera): This category might include other brand name drugs that are medroxyprogesterone acetate. Space restrictions on the form do not allow us to list all possible brand names, so we have chosen the most commonly recognized name.

Other (Specify): This category for example, would include "cervical cap" or any other form of birth control not listed. You must always specify the method.

**ITEM 14. PROCEDURE THAT TERMINATED THIS PREGNANCY
(Check only one)**

Suction Curettage, Medical (nonsurgical)-Specify medication(s),
Dilation and Evacuation (D&E), Intra-Uterine Instillation
(Saline/prostaglandin), Vaginal Prostaglandin, Sharp Curettage

(D&C), Other (Specify)

Check the box that describes the primary procedure that actually terminated this pregnancy. Check only one box. If more than one procedure was used, identify the other procedure(s) in item 15. If a procedure not listed was used, check "Other" and specify on the line provided. Do not report Laminaria as the procedure that terminated the pregnancy.

If more than one entry is checked, the report form will be returned for your determination in which one procedure terminated this pregnancy.

DEFINITIONS OF CERTAIN TERMINATION PROCEDURES CAN BE FOUND AT THE END OF THESE INSTRUCTIONS.

This item provides information on the frequency of specific procedures. When used in conjunction with other procedures used and length of gestation it provides an indication of the safety, appropriateness, and health risks of the various termination procedures at different gestational ages.

**ITEM 15. OTHER PROCEDURES USED FOR THIS TERMINATION
(Check all that apply)**

None, Suction Curettage, Medical (nonsurgical)-Specify medication(s), Dilation and Evacuation (D&E), Intra-Uterine Instillation (Saline or prostaglandin), Vaginal Prostaglandin, Sharp Curettage (D&C), Other (Specify)

Check the box(es) that describe other procedure(s) used. If no additional procedures were used, check the "none" box. If a procedure not listed was used check "Other" and specify on the line provided.

This question is asking only about "Other Procedures Used for this Termination". Do not check the same procedure that was indicated in question 14. If you want to report the use of Laminaria this would be the appropriate place. You would check the "other" box and specify Laminaria.

This item provides information on the incidence of termination involving multiple procedures. When used in conjunction with primary procedures and length of gestation it provides an indication of the safety, appropriateness, and health risks of the various termination procedures at different gestational ages.

ITEM 16. WAS WRITTEN POST-OPERATIVE /AFTER CARE INFORMATION GIVEN TO PATIENT?

Yes No

Check one box. Do not leave this item blank.

ITEM 17. WAS FOLLOW-UP VISIT RECOMMENDED?

Yes No

Check one box. Do not leave this item blank.

**ITEM 18. COMPLICATIONS AT TIME OF PROCEDURE
(check all that apply)**

None, Hemorrhage, Infection, Uterine perforation, Cervical laceration, Retained products, Failure of first method, Other (specify).

Indicate none or any complications that occurred at the time of the procedure. Check all that apply. Do not leave this item blank.

ITEM 19. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED AT THIS FACILITY?

Indicate if a follow-up visit occurred at this facility. No Yes

If "YES", specify complications: none or any complication that was reported at the time of the follow up visit. Check all that apply. Do not leave this item blank.

Include only information that is available to you at the time you are completing the report form. We do not want you to indicate that the patient has a scheduled follow up visit or they did not come in for their scheduled appointment. If the visit has not occurred at the time of completion of this form, you should indicate “no” for the follow up visit.

ITEM 20. AT THE TIME OF COMPLETION OF THIS REPORT FORM HAD A FOLLOW UP VISIT OCCURRED OUTSIDE THIS FACILITY?

Indicate if a follow up visit occurred outside this facility.

No Yes Unknown

If “YES”, check the appropriate complications: none, unknown or any complication that was reported to you by an outside source. Check all that apply. Do not leave this item blank.

Include only information that is available to you at the time you are completing the report form. We do not want you to indicate that the patient has a scheduled follow up visit. If the visit has not occurred at the time of completion of this form, you should indicate “no” for the follow up visit.

We have provided a space for you to indicate “unknown” when you do not have the information regarding follow up visits “outside” your facility. We also have provided an “unknown” for complications, to be used when you know a follow up visit occurred outside your facility, but do not know if any complications occurred.

ITEM 20A. IF YES, SPECIFY LOCATION OF FOLLOW UP VISIT.

Physician’s Office, Clinic, Hospital, Other (specify).

This question is answered ONLY if question 20 is indicated as “yes”, otherwise leave this question blank. Check one of the categories listed or specify the site.

Persons filing reports under ORS 435.496 are required to note if the person undergoing a termination of pregnancy returned for a follow up visit or had follow

up contact and whether any complications occurred as a result of the termination of pregnancy procedure. This reporting is only required if the contact or follow-up visit occurs prior to the report being filed. If persons filing the report are aware that a contact or follow up visit occurred with someone other than the termination provider, then the source of that information will be provided in the report. Information about contacts, follow up visits or complications which are received by the provider after the report is filed, are not required to be reported.

Please complete each report form no sooner than 2 weeks following the date of termination.

Form must be completed and mailed no later than 30 days following the date of termination of pregnancy.

If questions are not completed on the report form, they will be sent back to the facility/provider for completion. Facilities are responsible for obtaining the information required on the report forms. Every question asked on the report form is required by law to be completed. Some of the information can only be obtained from the patient. The personal information needs to be asked and obtained from the patient and the medical information obtained from medical history/record files. All necessary information should be made available to the person who completes the reporting form for the facility.