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
   (specify): _____

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): _____

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): _____

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): _____

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): _____

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): _____
   23b. Complications:
   ☐ None ☐ Hemorrhage ☐ Infection ☐ Uterine perforation ☐ Cervical laceration
   ☐ Retained products ☐ Failure of first method ☐ Unknown ☐ Other (specify): _____

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.)

WHEN COMPLETING THIS FORM,
DO NOT WRITE OR STAMP ANY INFORMATION IN THE TOP RIGHT CORNER.
This space is required for recording the state file number.

DO NOT PUNCH HOLES IN THE TOP OF THIS FORM.
This prevents us from using our numbering machine for assigning state file numbers.
You may punch holes in the bottom or sides.

SEND COMPLETED FORMS TO: CENTER FOR HEALTH STATISTICS
P.O. BOX 14050
Portland, OR 97293-0050

"Induced Termination of Pregnancy" is defined as "the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and that does not result in a live birth." This definition excludes management of prolonged retention of products of conception following fetal death.

In accordance with ORS 435.496, each induced termination of pregnancy which occurs in the State of Oregon, regardless of the length of gestation, shall be reported to the Center for Health Statistics within 30 days by the person in charge of the institution in which the induced termination was performed or, if not in an institution, by the attending physician.

This report is designed to collect information for statistical and research purposes only and is not maintained as a permanent file at the Center for Health Statistics. The data gathered from this report are presented in aggregate statistics only. By law, no identifying information is collected about the abortion patient and all provider information is kept strictly confidential.

It is the responsibility of each abortion provider to obtain an answer for each of the questions asked on this form. For information about completing the data items on this form, you can contact 971-673-1160 or you can refer to the "Instructions for Completing The Report of Induced Termination of Pregnancy."

The instructions are available online at:
http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/ITOPInstruct.aspx

Additional copies of this form can also be downloaded at the above listed web address.

Additional forms may also be ordered and mailed to you by completing a Request for Vital Records Forms and Tags, Form 45-43.

The request form is available by calling 971-673-1180, or online at:
http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Documents/45-43.pdf.

This report may also be filed electronically through the Oregon Vital Events Registration System (OVERS). Please contact the OVERS team at 971-673-0279 if you are interested in learning more about using OVERS to submit reports electronically.