003680

TERMINATED PREGNANCY REPORT

State Form 35526 (R4 / 12-11)
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

☐ PLEASE CHECK IF AN AMENDED FORM.

Mail completed form to: Indiana State Department of Health
P. O. Box 7125
Indianapolis, IN 46204

** If the patient is less than fourteen (14) years of age the physician performing the termination shall transmit this report to the Department of Child Services within three (3) days after the termination is performed via email at dcshotlinereports@dcs.in.gov.
Further, this report shall also be mailed to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be mailed to the Indiana State Department of Health no later than July 30 for each termination performed in the first six (6) months of that year and no later than January 30 for each termination performed for the last six (6) months of the preceding year.
Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility name *(If not a hospital or clinic, please enter address.)*	City or town, of pregnancy termination	County of pregnancy termination
WOMAN'S PAVILION	SOUTH BEND	ST. JOSEPH

Patient's age**	Married	Date of pregnancy termination *(month, day, year)*	Education *(Enter highest grade completed.)*
14	☐ Yes ☒ No	8/8/2014	9th GRADE

Race *(Select one or more.)* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☒ White ☐ Other

Ethnicity ☐ Hispanic or Latino ☒ Not Hispanic or Latino

Live Births:	Number now living *(enter number or check None)* ☒ None	Number now deceased *(enter number or check None)* ☒ None
Other Terminations:	Number of spontaneous terminations *(enter number or check None)* ☒ None	Number of induced terminations *(enter number or check None)* ☒ None

Dates of terminations *(Do not include this termination.)*
1. ____ 2. ____ 3. ____ 4. ____ 5. ____ 6. ____
7. ____ 8. ____ 9. ____ 10. ____ 11. ____ 12. ____

Fetus delivered alive?	Fetus viable?	If viable, medical reason for termination:
☐ Yes XXXXXNo	☐ Yes XXXXXNo	

Pathological examination performed?	If yes, results:
XXXXXXes ☐ No	PRODUCTS OF CONCEPTION

Type of Termination Procedures

Procedure that Terminated pregnancy *(check one only)*	Additional Procedures used for this termination, if any *(check all that apply)*
☐ Medical (nonsurgical) Mifepristone / Misoprostol	☐
XXXXX Suction Curettage	☐
☐ Menstrual Aspiration	☐
☐ Medical (Nonsurgical) Specify Medication(s) ____	☐
☐ Medical (Surgical) Other *(Specify)* ____	☐

Complication(s) of Pregnancy Termination *(Check all that apply.)*

XXXXX☐ None ☐ Uterine Perforation
☐ Hemorrhage ☐ Cervical Laceration
☐ Infection ☐ Retained Products
☐ Other *(Specify)*: ____

Did this termination of pregnancy result in a maternal death?
☐ Yes XXXXXXX☐ No

Date last normal menses began *(month, day, year)*	Physician estimate of gestation *(in weeks)*	Postfertilization age of the fetus *(in weeks)*
6/3/14	7	UNKNOWN

How determined: ULTRASOUND ABDOMINAL ~~TRANSVAGINAL~~

My signature certifies this termination was performed according to IC 16-34-2.

Signature of physician performing termination	Full name of physician performing termination
	DR. ULRICH G. KLOPFER

Address of physician performing termination *(number and street, city, state, and ZIP code)*
2010 IRONWOOD CIRCLE SOUTH BEND, IN. $46635

DATE RECEIVED BY ISDH *(month, day, year)*: **RECEIVED** AUG 0 8 2014